From: Beatrice Morgan [redacted]
Subject: RE: [EXTERNAL] Re: (00186383/1) - IBI notification of intention to publish GMC complaint
Date: 20 August 2020 at 16[redacted]0[redacted]
To: Gregory Murphy [redacted]
Cc: anneanakin[redacted] Sarah Westoby [redacted]

Dear Mr Murphy and Mrs Anakin

I confirm receipt of your email below and attachment. I note that you have included Mike Moore in your email. I have forwarded this document to our contacts at the Inquiry as well, to ensure that it reaches the right team as quickly as possible.

Please do not hesitate to contact me if you would like to discuss further.

Kind regards

Beatrice

Beatrice Morgan, Assistant Solicitor to Emma Jones

[redacted]

[redacted]

Leigh Day

From: Gregory Murphy <g[redacted]>
Sent: 20 August 2020 16[redacted]6
To: Sarah Westoby <[redacted]k>; Mike Moore <mike.moore@ GRO-C ; Beatrice Morgan <[redacted]>
Cc: Anne Anakin <[redacted]>
Subject: [EXTERNAL] Re: (00186383/1) - IBI notification of intention to publish GMC complaint

Dear Ms Westoby, Ms Morgan and Mr Moore,

Please find enclosed (PDF attached) an admittedly late response – exactly 24 hours – to the materials sent to us a week ago, which we thank you for.

As per previous discussions with both Leigh Day and the IBI, we have submitted this to both channels simultaneously as per our stated preferences to always have the ability to deal as fluidly as possible with both parties.

In the event that we have irrevocably missed yesterday's deadline to the extent that our response is now rendered worthless, then we would ask the courtesy that at least sections 1, 5 and 7 of our submission are read by officials at some point.

The above three sections contain very pertinent, indeed also highly sensitive and confidential, strands of information relating to the further progress of our evidence submissions to the IBI, which we feel that you should be aware of in any case.

Yours sincerely,

Anne Elizabeth Anakin (dob: GRO-C 60); Gregory William Murphy (dob: GRO-C 67)

encl.

On 13 August 2020 at 10[redacted]0, Sarah Westoby <[redacted]> wrote:

> Dear Mr Murphy,
>
> The email below, with attachment, did not send due to the size of the attachment. I am therefore sending it again with this email on this secure link, which needs to be accessed within seven days: [redacted]
>
> Please note the link requires a password which I have texted to you.
>
> Kind regards,

[redacted] [redacted]

Sarah

Sarah Westoby, Solicitor to Emma Jones

Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB

[redacted]

From: Sarah Westoby
Sent: 13 August 2020 11[redacted]8
To: 'gregmurph [redacted] <[redacted]>
Subject: (00186383/1) - IBI notification of intention to publish GMC complaint

Dear Mr Murphy,

I hope you and your family are well in these difficult times.

The Inquiry has notified us that later this month it plans on disclosing material from the General Medical Council ("GMC") that includes a complaint by Maureen Murphy (on behalf of Mr William Murphy) against Dr Ian Thomas Gilmore (1504220) & Dr Charles Hay (2310390), GMC Reference: 2004/0781.

The Inquiry has reviewed the whole complaint file, however they will only be disclosing the relevant aspects of the file (as per the attachment we have

[redacted]

[redacted]

received from the Inquiry). Your family's names have been redacted from the documents prior to disclosure. The document is password protected, I will text you the password now.

If you have any comments or concerns regarding disclosure of this file, please contact me by 18th August 2020, as the Inquiry have asked us to notify them of any issues or concerns by 4pm on Wednesday 19th August 2020.

Please note I am on annual leave from Friday 14th August. If you wish to contact us after this time please contact my colleague Beatrice Morgan (BMorgan[redacted]

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones

Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB

[redacted]

[redacted]

Witness Name: Charles Hamilton Massey
Statement No.: WITN3365011
Exhibits: WITN3365012-WITN3365031
Dated: 30 August 2019

INFECTED BLOOD INQUIRY

EXHIBIT WITN3365023 OF MR CHARLES HAMILTON MASSEY

WITN3365023 – Exhibit: Complaint by Mrs GRO-A (on behalf of her deceased husband Mr GRO-A against Dr Ian Thomas Gilmore (1504220) & Dr Charles Hay (2310390). GMC Case Reference: 2004/0781

GENERAL
MEDICAL
COUNCIL
Protecting patients, guiding doctors

Case Examiner Decision Form

Investigation Officer: Tim Cox-Brown

File Reference No 2004/0781/1 Date 140205

Dr's Name Charles HAY Reg No 2310390

Part 1.

Nature of Allegations

Date complaint first received by the GMC: 220304

Year alleged events took place: 1990

The following are the allegations raised by the complainant and/or employer: (TO BE NUMBERED)

That Dr Hay;

1. Failed to diagnose liver disease in GRO-A
2. Failed to test for Hepatitis C
3. Failed to refer to hepatologist
4. Failed to communicate the clinical condition of "liver failure" to the patient
5. Failed to refer or recommend liver transplant
6. Refused to refer to specialist Dr Gilmore
7. Failed to diagnose and treat liver cancer early enough
8. Prevented full liver tests being undertaken

Nature of Allegations: presumption of impaired FTP

1.1 Do the allegations fall within one of the categories where there is a presumption, if proven, of impaired fitness to practise to a degree justifying action on registration?

Sexual Assault or indecency	**Yes**	**No**
a. Indecent behaviour	☐	☒
b. Indecent assault	☐	☒
c. Rape/attempted rape	☐	☒
d. Female circumcision	☐	☒
e. Child pornography	☐	☒
Violence		
f. Assault	☐	☒
g. Attempted murder	☐	☒
h. Firearms offence	☐	☒
i. Murder/manslaughter	☐	☒
j. Robbery	☐	☒
Improper sexual/emotional relationship	☐	☒
Dishonesty		
k. False claims to qualifications/experience	☐	☒
l. Financial fraud/deception	☐	☒
m. Forgery/improper alteration of documents	☐	☒

n. Research misconduct	☐	☒
o. False certification, false reporting	☐	☒
p. False claims about effectiveness of treatment	☐	☒
q. None of the above dishonesty allegations	☒	☐

Part 2.

Nature of allegations: Good Medical Practice

2.1 Do the allegations relate to one or more of the principles of Good Medical Practice set out below? If yes, please tick and cite the relevant paragraph in the right hand column then go to Part 3.
If no, please tick ' None of the above' then go to Part 3.

(For more detail on the principles of GMP, refer to the GMP booklet and the guidance provided.)

		Para(s) in GMP
a. Good Clinical Care	☒	2, 3
b. Maintaining Good Medical Practice	☐	
c. Teaching and Training	☐	
d. Relationships with patients	☐	
e. Working with colleagues	☐	
f. Probity	☐	
g. Health	☐	
i. None of the above GMP allegations	☐	

Part 3

Criteria for assessing the seriousness of allegations

Questions 3a to 3g will help to identify whether the allegations are sufficiently serious to meet the Investigation stage test: 'Is there a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration?'

Please tick yes or no in each section

Do the allegations indicate that:

	Yes	No
a. the doctor's performance has harmed patients or put patients at risk of harm?	☒	☐
b. the doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients?	☒	☐
c. the doctor has abused a patient's right or violated a patient's autonomy or other fundamental rights?	☐	☒
d. the doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others?	☐	☒
e. the doctor's behaviour is such that public confidence in doctors generally might be undermined if the GMC did not take action?	☐	☒
g. the doctor's health is compromising patient safety?	☐	☒

Part 4

Realistic prospect test

4.1 Is there a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration

Yes ☐

No ☒

4.2 Please give reasons for your decision

1. GRO-A widow has investigated a civil action for damages and the expert opinions are included on file. They do not support her allegations and accordingly her solicitors dropped the action. Dr hay was closely monitoring liver function tests. Cirrhosis of the liver was diagnosed in 1992 following knee surgery. There is nothing to indicate that this surgery was contraindicated or had any adverse effect on GRO-A liver disease. GRO-A own expert hepatologist confirms that this is the case and that earlier diagnosis via biopsy would have been very unusual practice at the time. *Fails realistic prospect test.*

2. The hepatitis C test only became available in late 1991 and Dr Hay began testing in early 1992. This is not an issue to justify action on a Dr's registration - fails realistic prospect test

3. In this context Dr Hay was an experienced consultant and it was reasonable for him to manage GRO-A care himself. The independent expert view was that the liver disease was appropriately managed with very effective treatment of the patient's oesophageal varices. No action on registration indicated as fails realistic prospect test

4. GRO-A liver function was regularly monitors and discussions about the diagnosis documented. There is no evidence that any information was deliberately withheld so no action on registration indicated as fails realistic prospect test

5. At the time it is clear liver transplantation was a last resort measure, particularly with the increased morbidity and mortality associated with patients who had haemophilia. When his liver function deteriorated GRO-A was referred. Unfortunately this deterioration coincided with the diagnosis of a malignant liver tumour so removing transplantation as an option

6. GRO-A was referred to Dr Gilmore. Unfortunately it was at a stage when the hepatoma was diagnosed. There is no evidence that Dr hay or any other Dr failed to act on evidence that would have led to an earlier diagnosis

7. The blood test result indicating a possible hepatoma was 1st recorded in excess of 9000 in July. By August it was greater than 1000000. This is a large rise in a short space of time and occurred in combination with the patient's worsening clinical condition. It was not routine accepted practice to "screen" patients with cirrhosis for liver cancer and Dr Hay's management is what might reasonably have been expected. No issue indicating action on registration – fails realistic prospect test

8. "A full liver work up" may have involved risk laden procedures such as liver biopsy, the complications from which are multiplied in patients with a bleeding disorder such as haemophilia. Professor Shields discussed the pros and cons with the haemophilia specialist

– Dr Hay, who can be said to have been acting in his patient's best interests. No issue justifying action on registration – fails realistic prospect test

Part 5

Undertakings

5.1 Do you consider that this is a case where undertakings should be offered to the doctor?

Yes ☐

Case Examiner Referral Form

Section 1: Case Details

See Notes on Completion at end of form

FPD reference RG/FPD/2004/0781

Doctor's name HAY, Charles

Registration no. 2310390

Date 140205

Investigation Officer Richard Grumberg

File location: E:\.... NR

Section 2: Previous History

See Note 1

Previous history? Yes

FPD Reference	Nature of complaint	Outcome/current status
2003/0206	Substandard clinical practice	Open

Section 3: Index complaint – background and summary

The complaint is made by the widow of Mr. GRO-A, a haemophiliac who died of liver cancer in September 1994.

Flag 1 is the case against Dr. Hay as set forth by GRO-A. In essence the allegations can be summarised as follows:

1. That Dr. Hay was fully aware of the prevailing issues facing the haemophiliac community in the period 1975 – 1994 and in particular the presence of progressive liver disease that affected haemophiliacs but did not foresee, or even recognise, the clinical manifestations of liver disease in GRO-A
2. Dr. Hay did not conduct any testing for Hepatitis C on GRO-A even though he knew, or should have known, that GRO-A y was in a high-risk category for infection of that virus. This failure to test GRO-A meant that his hepatitis C positive status was not discovered until January 1992 when the virus had progressed unchecked to the point where he was suffering from cirrhosis of the liver, with Dr. Hay estimating that he only had 2½ years left to live.
3. Dr. Hay did not refer GRO-A to a Hepatologist, even when it was clear that he was Hepatitis C positive and suffering from cirrhosis of the liver.
4. Dr. Hay did not iniform GRO-A that he was in the clinical phase known as liver failure.
5. Dr. Hay did not recommend GRO-A for a liver transplant.
6. Refused to refer to specialist Dr. Gilmore
7. Failed to diagnose and treat liver cancer early enough
8. Prevented full liver tests being undertaken

The following points should be noted and correspond numerically to each point above:

1. GRO-A widow has investigated a civil action for damages and the expert opinions are included in the file. They do not support her allegations and accordingly her solicitors dropped the action. Dr. Hay was closely monitoring liver function tests. Cirrhosis of the liver was diagnosed in 1992 following knee surgery. There is nothing to indicate that this surgery was contraindicated or had any adverse effect on Mr. GRO-A liver disease. GRO-A own expert hepatologist confirms that this is the case and that earlier diagnosis via biopsy would have been very unusual practice at the time.
2. The hepatitis C test only became available in late 1991 and Dr. Hay began testing in early 1992.
3. The independent expert view was that the liver disease was appropriately managed with very effective treatment of the patient's oesophageal varices. Dr. Hay was an experienced consultant and it appears that it was reasonable for him to manage GRO-A care himself.

4. GRO-A liver function was regularly monitored and discussions about the diagnosis documented. There is no evidence that any information was deliberately withheld.
5. At the time it is clear liver transplantation was a last resort measure, particularly with the increased morbidity and mortality associated with patients who had haemophilia. When his liver function deteriorated Mr. GRO-A was referred. Unfortunately the reason for the deterioration, a malignant liver tumour meant that transplantation was not an option.
6. GRO-A was referred to Dr. Gilmore. Unfortunately, it was at a stage when the cancer was diagnosed. There is no evidence that Dr. Hay or any other Dr. failed to act on evidence that would have led to an earlier diagnosis.
7. The diagnosis of GRO-A liver cancer was made following his *transfer to Newcastle in August 1994. This followed deterioration in his* liver function tests and clinical condition, which had previously been stable. It was not accepted practise to screen patients with cirrhosis for liver cancer and there is nothing to suggest that earlier diagnosis or treatment could reasonably have been expected.
8. A 'full liver workup' would have involved invasive and risky procedures. Prof. Shields deferred to Dr. Hay's greater expertise in the treatment of haemophilia and the risks compared to the benefits given the other clinical information available on GRO-A condition. There is nothing to suggest that Dr. Hay was doing other than acting in what he felt to be his patient's best interests.

Section 4: Additional information

None but for the previously mentioned expert opinions in the file.

Section 5: Performance Assessments/Health Examinations

None.

Section 6: Summary of Allegations

See Note 5

A	B	C	D
No	**Allegation**	**Presumption of impaired FTP?**	**Breach of GMP?**
1	Failed to diagnose liver disease in GRO-A	No	Yes
2	Failed to test for Hepatitis C.	No	Yes
3	Failed to refer to hepatologist	No	Yes
4	Failed to communicate the clinical condition of "liver failure" to the patient.	No	Yes
5	Failed to refer or recommend liver transplant.	No	Yes
6	Refused to refer to specialist Dr. Gilmore.	No	Yes
7	Failed to diagnose and treat liver cancer early enough	No	Yes
8	Prevented full liver tests being undertaken	No	Yes

Other relevant guidance? No

See Note 6

Section 7: Charges

None.

Section 8: Conclusion/Suggested Action

It does not appear from the above that the realistic prospect test can be satisfied, however I welcome the medical case examiner's view on the issue.

Casework Screening Memo and Screening Decision Form
Part 2 – Screeners to complete

Section 7: Conduct

Medical Screener's decision on each allegation *(Note, it is possible that whilst individual allegations do not raise issues of SPM/SDP the totality of 2 or more allegations may do so. Record such instances in the reasons section)*

Dr ____Hay____________

No	**Allegation**	**Category** *[drawn from Annex A]*	**SPM by definition?**	**Part 1 screening test met?**	**If part 1 is met, is part 2 also met?**
1	Dr Hay failed to diagnose liver disease in GRO-A GRO-A	Substandard treatment.	Discretion	N	
2	Dr Hay failed to test for Hepatitis C	"	"	N	
3	Failure to refer to hepatologist	"	"	N	
4	Failure to communicate clinical condition to patient ("liver failure")	"	N	N	
5	Failure to refer or recommend liver transplant	"	Discretion	N	
6	Refusal to refer to specialist, Dr Gilmore	"	"	N	
7	Failure to diagnose and treat liver cancer early enough	"	"	N	
8	Prevented "full liver work up" i.e. proper investigation	"	"	N	

Reasons

Allegation number	Reasons
1	Dr Hay was clearly aware of the issues affecting haemophiliac patients and monitored GRO-A condition (clinically and via blood tests regularly). It is accepted that GRO-A blood tests were stable *prior* to his knee operation
2	Testing for hepatitis C was not widely available until late 1991. The issues *of prognosis were not fully understood, so treatment options limited*
3	Dr Hay had wide experience of patients with hepatic complications of blood disorders and worked with Professor Shields, a surgeon specialising in the treatment of liver problems, such as the oesophageal varices which GRO-A had
4	Whilst failure to tell a patient about a condition they were suffering from is clearly not good practice, there is no evidence to suggest that Dr hay failed to advise GRO-A about his liver problems. Consequently I do not feel that this is properly arguable as SPM. GRO-A was having regular monitoring including blood tests for liver function
5	The prevailing opinions at the time were conflicting. A liver transplant was clearly highly risky, more so in a patient with Hepatitis C. It is clear the option was considered, but unfortunately by the time it was indicated Mr GRO-A had developed a rare complication of hepatoma. I do not think that failure to refer can be said to represent SPM. Most forms of more conservative treatment (e.g. medication, sclerotherapy) are used to try to avoid surgery for as long as possible
6	Mr GRO-A *was referred to Dr Gilmore. Unfortunately it was at a stage* when the hepatoma was diagnosed. The case for SPM cannot be properly argued as there is no evidence that Dr Hay or any other Dr failed to act on any evidence that would have led to a *significantly earlier diagnosis*
7	The blood test result indicating a possible hepatoma was 1st recorded in excess of 9,000 in July. By August it was >100,000. This is a large rise in a short space of time. In combination with the patient's worsening clinical condition, with ascites the patient was transferred. Screening is controversial and the management of Dr Hay was what might reasonably have been expected at that time
8	Failure to conduct a "full liver work up" meant preventing Mr GRO-A from having potentially risky invasive procedures performed. Whilst with hindsight it may have been useful it is not properly arguable that this was done in anything other than consideration of the patient's best interests

Comment

The case has been considered outside the 5 year rule because of the wider public interest prevailing with a series of Haemophilia and hepatitis C cases. However I do not feel that given the responses of Dr Hay and consideration of specific allegations that the case should go before the PPC. The case will now be considered by a lay case examiner.

Section 8: Performance

This/these allegations raise issues of seriously deficient performance *for the following reasons:*

Dr ________________

Reasons

Section 9: Summary and Decision – Medical Screener

Copy this page for each doctor named in this complaint

To be completed by the Medical Screener:

In my view this case raises:

Tick one box only

a. Issue(s) of spm (only) and should be referred to the next available PPC ☐ ∏ *Sign, date below and return to the CW*

b. Issue(s) of sdp (only) and a performance Rule 6 letter should be sent ☐ ∏ *- ditto -*

c. Issues of **both** spm and sdp ☐ ∏ *go to 9e*

d. No issues of spm **or** sdp ☐√ ∏ *Sign, date below and return to the CW*

e. In my opinion this case should be considered in accordance with:

Tick one box only

1. The *conduct procedures* ☐ ∏ *Refer to next PPC*
2. The performance procedures ☐ ∏ *Performance R6 letter*

Signed Sarah Whiteman (Medical Screener)
Date 16.8.04

Action	**Draft Charges**	**Closure letters**
Approve		
Amend (discuss with CW)		
Re-Draft (discuss with CW)		

Section 10: Conduct

Lay Screener's decision on each allegation *(Note, it is possible that whilst individual allegations do not raise issues of SPM/SDP the totality of 2 or more allegations may do so. Record such instances in the reasons section)*

Dr_Hay Consutant Haemotologist

No	Allegation	Category *[drawn from Annex A]*	SPM by definition?	Part 1 screening test met?	If part 1 is met, is part 2 also met?
1	Failure to diagnose liver disease in high risk patient	Substandard treatment	By Discretion	Yes	no
2	Failure to test for Hep C	Substandard treatment	By Discretion	No	
3	Failure to refer to Hepatologist	Substandard treatment	By Discretion	No	
4	Failure to communicate clinical condition to patient	Substandard treatment	By Discretion	No	
5	Failure to refer for transplant	Substandard treatment	By Discretion	Yes	no
6	*Refusal to refer* appropriately to Dr Gilmore	*Substandard* treatment	By Discretion	Yes	no
7	Failure to diagnose & treat liver cancer early enough	Substandard treatment	By Discretion	Yes	no
8	Prevention of proper investigation ie by Prof Shield	Substandard treatment	By Discretion	Yes	no

Reasons

Allegation number	Reasons
1	This case concerns GRO-A a haemophiliac who died of liver cancer in Sept 1994 He had been infected, probably in 1981, with hepatitis C from infected blood products used in the treatment of his haemophilia, which directly increased his risk of liver disease. His widow makes a number of allegations about the quality of the treatment her husband received and believes that Dr Hay, his haematologist, failed to monitor or adequately treat her husband's liver disease .She has investigated a civil action for damages and the expert opinions she obtained are included on the file. They do not support her allegations and accordingly her solicitors dropped the action. It is clear in respect of this particular allegation that Dr Hay was

	closely monitoring GRO-A via liver function tests and that Cirrhosis of the liver was diagnosed in early 1992 following his knee surgery. There is nothing to indicate that this surgery was contraindicated or had any effect on the progress of GRO-A liver disease. GRO-A own expert Hepatologist, Dr Mervyn Davies confirms that this is the case and that earlier diagnosis via biopsy would have been very unusual practice at this time. There is therefore no properly arguable case that SPM/SDP occurred.
2	The test for Hepatitis C only became widely available in late 1991 and this allegation cannot therefore reach the threshold of SPM/SDP as Dr Hay began testing GRO-A in March 1992 i.e. within a short time of the test becoming available.
3	As Dr Hay was very experienced and knowledgably about the development of liver disease in this context it was reasonable for him to manage GRO-A care himself .The independent expert view is that the liver disease' was appropriately managed with very effective treatment of (his) varices.' This allegation does not therefore reach the threshold of SPM/SDP as given the treatment being provided referral was not necessary at this stage.
4	GRO-A was clearly aware that he was being monitored for liver disease and once a diagnosis of cirrhosis was made this was fully discussed with the patient and his wife. There is nothing to suggest that any information was deliberately concealed from the patient and the exact terminology used in discussion with *patients of a diagnosis may vary between clinicians. This allegation does not* reach the threshold of SPM/SDM.
5	This issue is addressed at length in expert reports and it is clear that the indications for transplantation at the time were ones of last resort particularly given the additional morbidity associated with Haemophiliac patients GRO-A GRO-A was referred at the point when his liver function tests showed a severe deterioration. Unfortunately the reason for the deterioration, a malignant liver tumour meant that transplantation was not an option. There is however no properly arguable case that SPM/SDP has taken place.
6	The referral to Dr Gilmore was made at the point when the cancer was diagnosed but there is nothing to suggest that there were earlier indications, which would have made such a referral imperative, or that it would have altered the course of events. SPM/SDP is not therefore properly arguable.
7	The diagnosis of GRO-A liver cancer was made following his transfer to Newcastle in August 1994.This followed deterioration in his liver function tests and clinical condition, which had previously been stable. It was not accepted practise to screen patients with cirrhosis for liver cancer and there is nothing to suggest that earlier diagnosis or treatment could reasonably have been expected. There is not therefore a properly arguable case that SPM/SDP has taken place.
8	There was clearly a disagreement between Dr Hay and Prof Shields about the timing of a 'full liver workup', which would have involved invasive and risky procedures. Prof Shields deferred to Dr Hay's greater expertise in the treatment of haemophilia and the risks compared to the benefits given the other clinical information available on GRO-A condition. Whether this would have changed the later course of events is debatable and there is nothing to suggest that Dr Hay was doing other than acting in what he felt to be his patient's best interests. There is no therefore a properly arguable case that SPM/SDP has occurred.

Section 11: Performance

This/these allegations raise issues of seriously deficient performance for the following reasons:

Dr _______________

Reasons

Section 12: Summary and Decision – Lay Screener

To be completed by the Lay Screener

a: Do you agree with the Medical Screener's decision at 9d. above?

Yes ☑ ∏ *Sign, date and return to the CW*

No ☐ ∏ go to b below

Signed (Lay Screener) GRO-C

Date 17/8/04

b: Please state briefly why you do not agree with the Medical Screener's decision at 9d.

Sign, date and return to the CW

Signed (Lay Screener)

Date

Casework Screening Memo and Screening Decision Form
Part 1 – Caseworkers to complete

NOTE:

Sections 1-6 of this memo should be completed by caseworkers for every case referred to screeners for a decision, except cases involving a criminal conviction. Where a case has multiple doctors, they can be included on this form. However, where we receive adverse information from Drs' employer(s) which raise separate issues for consideration by the screener, a separate form must be completed.

Sections 7-9 should be completed by the medical screener. Sections 10-12 should be completed by the lay screener in cases where the medical screener seeks to conclude the complaint. On completion of the relevant sections the form must be returned to the caseworker for final action.

Draft charges, Rule 6 or closure letters should be attached to the file by the CW in all cases where a recommendation is made to close or proceed. The screeners should comment on these at section 9 & 11. Drafts should not be attached in cases where no recommendation is made.

Section 1: Case details

FPD complaint reference 2 0 0 4 0 7 8 1 0 1

Date 1 6 0 8 0 4 (D D M M Y Y)

Dr's name HAY

Reg no 2 3 1 0 3 9 0

Complainant no 2 6 0 6 7

Insert a new line for each Dr subject to this complaint

Section 2: Previous History

NOTE: List below any previous complaints against each doctor. State clearly the date, nature and outcome of the case.

Where there is no history write NONE in the box below

Dr. Hay

FPD ref	Date of complaint and brief outline	Outcome and stage closed
	NONE (but see below)	

Insert a new previous history record for each Dr subject to this complaint

Section 3: Current Case Background

NOTE: Include a brief history of this case, noting significant events, times and dates. This should be cross-referenced to documents on file as necessary, using clearly marked tabs.

1. Dr. Hay has been identified. He has not been the subject of any previous complaints, but there is a current complaint about him, from a haemophiliac, which is attached for your attention (2003/0206). You will see that that complaint is to be closed with no further action. Mrs GRO-A complaint has already been considered by a Medical Screener, who was asked to decide whether the public interest required that we consider this complaint, despite the events leading to it having taken place over five years ago. The Medical Screener confirmed that we should consider only the complaint about Dr. Hay GRO-A also complained about Dr. Gilmore - see memo at Flag A below; this complaint has been closed). We have dealt with this complaint in the usual manner, including disclosure to Dr. Hay. At Flag B below is a copy of our Standards guidance issued in 1988 regarding the testing of patients for hepatitis C and HIV in the 1980s.

2. Mrs GRO-A initial complaint is at Flag 1. At Flag 2 is a summary of Mrs. GRO-A complaint about Dr. Hay, and a similar summary regarding Dr. Gilmore is at Flag 3. At Flag 4 is a statement which outlines details of Mr. GRO-A treatment, and further general information is at Flag 5. Mrs. GRO-A has also provided copies of Mr. GRO-A medical records, which are voluminous and are held separately from this file but which are available should you require them.

3. Dr. Hay's initial response to this complaint, provided by the MPS, is at Flag 6, and Mrs GRO-A comments thereon are at Flag 7. Dr. Hay's further comments are at Flag 10. Mrs. GRO-A has sent copies of expert opinions she obtained during the course of the aborted litigation referred to in her final comments, which are at Flags 8 and 9.

4. Mrs. GRO-A husband was a haemophiliac who was infected with hepatitis C probably as a result of receiving infected blood products during an operation to repair a duodenal ulcer in 1981. He died in September 1994 as a result of hepatocellular carcinoma, cirrhosis of the liver, hepatitis C, and haemophilia A.

Section 4: Summary of allegations

NOTE: Summarise all the complainant's / referrer's allegations against the doctor concerned (extend the table as necessary). In cases where there is more than 1 Dr include a table for each Dr showing the Dr's name.

If it is impossible to summarise allegations, please note that in the table and summarise at section 6. This will be particularly relevant in cases where there are performance concerns.

Dr Hay

No.	Allegation	Category *[drawn from Annex A]*	SPM by definition?	Part 1 screening test met?	If part 1 is met, is part 2 also met?
1	Dr. Hay was fully aware of the prevailing issues facing the haemophiliac community in the period 1975-1994, and in particular the prevalence of progressive liver disease as it affected haemophiliacs, but did not foresee, or even recognise, the clinical manifestations of liver disease in GRO-A	Sub-standard treatment	SPM by discretion	Yes	Yes
2	Dr. Hay did not conduct any testing for hepatitis C on GRO-A even though he knew, or should have known, that GRO-A was in a high-risk category for infection with that virus. This failure to test GRO-A GRO-A meant that his hepatitis C positive status was not discovered until January 1992, when the virus had progressed unchecked to the point where he was suffering from	Sub-standard treatment	SPM by discretion	Yes	Yes

No.	Allegation	Category *[drawn from Annex A]*	SPM by definition?	Part 1 screening test met?	If part 1 is met, is part 2 also met?
	cirrhosis of the liver, with Dr. Hay estimating he only had 2.5 years left to live.				
3	Dr. Hay did not refer GRO-A to a hepatologist, even when it was clear that he was hepatitis C positive and suffering from cirrhosis of the liver.	Sub-standard treatment	SPM by discretion	Yes	Yes
4	Dr. Hay did not inform GRO-A that he was "in the clinical phase known as 'liver failure'."	Sub-standard treatment	SPM by discretion	Yes	Yes
5	Dr. Hay did not recommend Mr. GRO-A for a liver transplant.	Sub-standard treatment	SPM by discretion	Yes	Yes
6	Dr. Hay "Vehemently protested" against GRO-A eventual referral to Dr. Gilmore claiming that he did not consider that Dr. Gilmore could achieve any more for GRO-A than Dr. Hay had done.	Sub-standard treatment	SPM by discretion	Yes	Yes
7	Dr. Hay was responsible, jointly with Dr. Gilmore, for failures in Mr. GRO-A treatment between June and September 1994. This includes an alleged failure by Dr. Hay to detect a large cancerous tumour in Mr. GRO-A liver, and a subsequent	Sub-standard treatment	SPM by discretion	Yes	Yes

No.	Allegation	Category *[drawn from Annex A]*	SPM by definition?	Part 1 screening test met?	If part 1 is met, is part 2 also met?
	attempt by Dr. Hay to deny that the tumour existed when he had examined Mr GRO-A				
8	Dr. Hay "wilfully obstructed a full liver work-up" from being conducted on GRO-A	Sub-standard treatment	SPM by discretion	Yes	Yes

Section 5: Relevant GMC / other Guidance

NOTE: Note here all GMC guidance relevant to any of the allegations above. In the vast majority of cases, you should refer to and state the relevant paragraph(s) of Good Medical Practice. Include any relevant guidance offered by other organisations, such as the Medical Royal Colleges. State clearly the publication, paragraph / page and content.

Section 6: Summary & Conclusions

Including concerns which raise issues of seriously deficient performance

Mrs. GRO-A has made some serious allegations which clearly reach the threshold of SPM, and which are properly arguable. I feel, therefore, that this complaint should be referred to PPC for further consideration. I have not drafted charges, however, as I should be grateful for your advice on this case.

I should also be grateful if you would confirm that the public interest requires that Mrs. GRO-A complaint about Dr. Hay should be referred to PPC despite the events giving rise to it occurring over five years ago.

I look forward to receiving your advice.

GRO-C

Tim Cox-Brown
Caseworker, Fitness to Practise Directorate
Direct Line: GRO-C; Fax: GRO-C
E-mail: tcoxbrown@GRO-C

Now pass this document to the screeners to record their decision.

A

Tim, 26.4.04 I agree with your assessment that the issues raised against Dr Hay are generic, and hence of public interest. Those concerning Dr Gilmore are specific and not of public interest. see below ✱

Memorandum **To** **Dr. Brian Keighley**

Date **8 April 2004**

2004/0781: GRO-A v. Dr. Charles Hay and Dr. Ian Gilmore

1. I wonder if you would be kind enough to consider this complaint which we have received from the widow of a haemophiliac, given that you have seen the last three we have received.

2. GRO-A complaint concerns events which are over five years old. At Flag A below is a copy of our Standards guidance issued in 1988 regarding the testing of patients for hepatitis C and HIV in the 1980s.

3. Mrs. GRO-A husband, GRO-A, who was a haemophiliac, died in GRO-A 1994. Mr. GRO-A had been infected with hepatitis C through contaminated blood products used in the treatment of his haemophilia. GRO-A's initial complaint is at Flag 1. A statement made by GRO-A in 1997 (in support of litigation) is at Flag 2, which describes the background to this complaint. Further information is at Flag 3. GRO-A has helpfully provided detailed accounts of her complaints about Drs. Hay and Gilmore, which are at Flags 4 and 5. At Flag 6 is an article by Dr. Hay entitled "Haemophilia and Liver Disease" and at Flag 7 is a paper (published in The Lancet in 1985, which Dr. Hay co-authored) entitled "Progressive Liver Disease in Haemophilia: An Understated Problem?". Please note that GRO-A has also sent copies of medical records and correspondence with the NHS which are so voluminous that I have not added them to the file, but which are available should you wish to see them.

4. Mrs. GRO-A alleges that Dr. Hay:

a) Was fully aware of the prevailing issues facing the haemophiliac community in the period 1975-1994, and in particular the prevalence of progressive liver disease as it affected haemophiliacs, but did not foresee, or even recognise, the clinical manifestations of liver disease in GRO-A
b) Did not conduct any testing for hepatitis C on GRO-A even though he knew, or should have known, that GRO-A was in a high-risk category for infection with that virus. This failure to test GRO-A meant that his hepatitis C positive status was not discovered until January 1992, when the virus had progressed unchecked to the point where he was suffering from cirrhosis of the liver, with Dr. Hay estimating he only had 2.5 years left to live.
c) Did not refer GRO-A to a hepatologist, even when it was clear that he was hepatitis C positive and suffering from cirrhosis of the liver.
d) Did not inform GRO-A that he was "in the clinical phase known as 'liver failure'."
e) Did not recommend GRO-A for a liver transplant.
f) "Vehemently protested" against GRO-A eventual referral to Dr. Gilmore claiming that he did not consider that Dr. Gilmore could achieve any more for Mr. GRO-A than Dr. Hay had done.
g) Was responsible, jointly with Dr. Gilmore, for failures in GRO-A treatment between June and September 1994. This includes an alleged failure by Dr. Hay to

✱ The issues re Dr Hay are 4 a) – d) & e) more equivocal.

GRO-C

detect a large cancerous tumour in GRO-A liver, and a subsequent attempt by Dr. Hay to deny that the tumour existed when he had examined GRO-A.

5. Mrs. GRO-A alleges that Dr. Gilmore:

a) Did not warn GRO-A that a bout of encephalitis in August 1994 was potentially a sign that his liver was failing.
b) *Did not note that* GRO-A *was suffering from a cancerous tumour (7cms in* diameter) which rendered a planned liver transplant impossible, despite extensive testing, and allowed GRO-A to be transferred to Newcastle Freeman Hospital for said liver transplant. It is alleged that he has not admitted that this tumour was present when GRO-A was transferred to Newcastle (13 August 1994), but has claimed that the tumour developed between the date of transfer and GRO-A return to Liverpool (18 August 1994), a matter of five days.
c) Did not urgently a bed for GRO-A on his return from Newcastle Freeman Hospital, and did not arrange chemotherapy for him as a matter of urgency, but rather conducted non-urgent varices reparation treatment instead. This further delayed the start of vital chemotherapy, and GRO-A sadly died from the effects of a burst tumour days before his first planned chemotherapy appointment.
d) Did not show any urgency regarding GRO-A treatment during the period 19 August 1994 to GRO-A 1994.

6. It appears to me that GRO-A complaint about Dr. Hay raises some serious issues which, although they focus mainly on treatment afforded to one person, have wider implications, and which could therefore require us to pursue this matter in the public interest despite the age of the events complained about.

7. GRO-A complaint about Dr. Gilmore, on the other hand, does not appear to raise any issues such that the public interest requires that we consider it despite its age, as it seems to mainly focus on specific treatment issues in a limited time frame.

8. Please advise (only) whether the public interest requires that we pursue Mrs. GRO-A complaints about Drs. Hay and Gilmore through our Screening procedures despite the events giving rise to them occurring over five years ago. If you do consider that we should pursue any of GRO-A complaints I should be grateful if you would indicate on what basis we should do so.

GRO-C

Tim Cox-Brown
Caseworker, Fitness to Practise Directorate
Direct Line: GRO-C
E-mail: tcoxbrown@GRO-C

GRO-A

RECEIVED
22 MAR 2004

16/3/04

Dear Mr Cox-Brown,

I am enclosing the following for your attention:

1) My Statement and Guide to Appendices
2) Letter to Professor GRO-D from C.R.M Hay
3) Letter to C.R.M Hay to Professor GRO-D
4) Letter from GRO-D to Professor GRO-D
5) Letter from Professor Bassendine to I.T. Gilmore
6) Letter from I.T Gilmore to Professor James
7) Liver transplant assessment

I would appreciate any comments you may have after reading the contents of the above, as I firmly believe that my husband was a victim of medical negligence.

yours sincerely GRO-A

([illegible])

GUIDE TO APPENDICES

i) "Haemophilia and liver disease". Article written by Dr. C R M Hay. Haemophilia Society bulletin (May 1991).

ii) Royal Liverpool University Hospital medical references No 1382. Letter from Dr C R M Hay dated (7.10.91) to Professor L Klennerman requesting consideration for knee replacement operation. Statements from Dr Hay " that there are no haemotological problems ".

iii) Occasional Survey : " Progressive liver disease in Haemophilia - an understated problem?". The Lancet (June 1985).

iv) Royal Liverpool University Hospital medical reference No 724. First recorded note of existence of " liver failure " (16.1.92).

v) Royal Liverpool University Hospital medical reference No 841 . Further recorded note of existence of " liver failure " (5.5.92)

vi) "Hepatitis C: The facts" . Produced by the Haemophilia Society, in conjunction with Professor Mike Makris, of the Royal Liverpool University Hospital. Lists the timescale for consideration of liver transplant.

vii) Royal Liverpool University Hospital, medical reference No 1425. Letter from Mr. Mark Hartley, Senior Surgical Registrar, to Dr. Ian Gilmore, hepatologist, requesting his involvement with my Husband (8.6.94).

viii) Newcastle Freeman Hospital medical records, clinical record by Professor M. Bassendine, ruling out possibility of transplant. (18.8.94).

ix) Newcastle Freeman Hospital medical records, letter from Professor M. Bassendine to Dr. Ian Gilmore, confirming the existence of cancer prior to Liverpool's referal to Newcastle. (19.8.94)

x) Royal Liverpool University Hospital medical reference No. 1061. Relevant blood count test prior to Liverpool's referal to Newcastle, confirming the existence of cancerous tumor via Alpha Feto Protein reading of 9280. (15.7.94).

xi) Newcastle Feeman Hospital medical records, clinical details showing increase in cancerous tumour since Liverpool's failure to recognise it via alpha Feto Protein reading of 10,000 (23.8.94)

xii) "Hepatitis C - The facts ". Produced by the Haemophilia Society in conjunction with Professor Mike Makris of the Royal Hallamshire Hospital stating that patients with cirrhosis should be recommended for alpha feto protein test readings at four monthly intervals.

xiii) Royal Liverpool University Hospital medical reference No. 373. Original ultra sound report following liver scan in Liverpool stating existence of " Well- defined round mass (6.5cm in diameter) ". (20.7.94).

xiv) Newcastle Freeman Hospital medical records, MRI liver scan dated 16.8.94 confirming 7cm mass. likely to represent hepatoma (cancer).

xv) Royal Liverpool University Hospital medical reference No. 194. Dated (18. 6.92) - clinical confirmation listing Dr. Hay's refusal for liver work -up.

xvi) Royal Liverpool University Hospital medical reference No. 191. Discharge summary (18.6.92) detailing further refusal for liver work-up as vetoed by Dr. Hay due to "limited likely benefit".

xvii) Royal Liverpool University Hospital medical reference No. 1433/1434 letter from Dr. Hay to Professor GRO-D Department of Haemotology, Royal Hallamashire Hospital, confirming Liverpool's failure to recognise cancerous tumour. Statement that "Alpha feto proteins have been negative" when in fact the opposite was the case.

xviii) Statement by my late Husband in his own handwriting detailing the deteriorating quality of his life in January 1994 for Social Security purposes.

xix) Royal Liverpool University Hospital medical reference No. 1409. letter of support from Dr. Hay, again for Social Security purposes, confirming poor quality of life.

xx) Letter of support from Royal Liverpool University Hospital Social Worker, Mrs. Linda Smith, confirming poor quality of life.

xxi) Personal correspondence from Dr. I. Gilmore to myself passing his condolences on my Husbands death. Statement to the effect that my Husband's "hopes were raised" by the late referral to transplant.

xxii) Correspondence between Dr. I Gilmore and Dr. C R M Hay refering to myself and my family's visit to Dr. I. Gilmore.

xxiii) Pesonal correspondence from Dr. Hay to myself.

RECEIVED
22 MAR 2004

STATEMENT

From myself, Mrs GRO-A, regarding my late husband, Mr GRO-A GRO-A (Date of Birth GRO-A34 / Date of Death GRO-A94) a haemophiliac, who died at the Royal Liverpool University Hospital as a result of:

i) **Hepatocellular carcinoma.**
ii) **Cirrhosis of the liver.**
iii) **Hepatitis C**
iv) **Haemophilia A.**

This statement has been made to support my pursuance of a medical negligence claim, through Irvings Solicitors, Liverpool, against the Royal Liverpool University Hospital.

After examining my late husband's medical records in detail, I wish to emphasise that it is my conviction that he was the subject of compounded medical negligence over a period of not less than 2 years and 10 months encompassing December 1991, to the date of his death, GRO-A 1994.

I have restricted details to the above period for the purposes of this statement only. I have done this both for ease and with a firm conviction that, although I am convinced my husband had certainly been the subject of medical negligence prior to December 1991, the clinical events in the last period of his life alone should provide enough evidence to substantiate my claim.

Although my statement concerns the 1991-94 period as stated, I have, as a matter of necessity, included occasional history and back-up references from prior to that period.

I base my statement around four key areas:

i) How was my husband allowed to undergo a knee-replacement operation in December 1991 when his haemotological / hepatological state clearly made him unfit for such a procedure ?

ii) Why, after diagnosis with cirrhosis of the liver in January 1992, followed by periods of oesophageal bleeding (varices), which are known indicators of the recognised medical state known as "liver failure" - which is one of the recognised starting points for consideration of liver transplantation - was all mention of such a possible procedure withheld until June 1994, when he was finally referred to a liver specialist ?

iii) Why, in July 1994, when preparations were underway to send my husband to the Freeman Hospital, Newcastle, for further tests re: a liver transplant, was the existence of cancer not noted at the RLUH ?

It is medically known that the hopes for a liver transplant are seriously undermined, if not eradicated, by cancer. My husband's cancer, as can be proved, was in existence in July 1994 in the form of a 6.5cm (diameter) tumour with an Alpha-fetoprotein reading of 9280. Liverpool's failure to spot this crucial indicator was duly noted by the clinicians in Newcastle.

iv) Why, on return to Liverpool on August 19 1994, with said tumour likely to be in excess, at that stage, of 7cm (diameter), was chemotherapy treatment not due to be administered until September 6 1994, which, as it transpired, proved to be three days after his death ?

This represents an unacceptable waiting period of 19 days for a patient with seriously defined cancer. My husband was actually discharged from the RLUH following treatment for varices just four days before his death.

---

1)

How was my husband allowed to undergo a knee-replacement operation in December 1991 when his haemotological / hepatological state clearly made him unfit for such procedure ?

In January 1992, as the medical records confirm, my husband was a patient at the Royal Liverpool University Hospital recovering from a knee-replacement operation, necessitated by his basic condition as a haemophiliac.

At this stage, and indeed for several years previously, I was inclined to believe, in the absence of information to the contrary, that my husband was free from infection due to contaminated NHS administered blood products.

We had known for some time that he was HIV negative, unlike his two haemophiliac brothers, who had both died of AIDS-related illnesses in 1989 and 1990.

We had previously been alerted to another possible blight on the haemophiliac community, known as *Hepatitis Non-a Non-b*. The existence of this disease, later to be medically defined as Hepatitis C, was brought to our attention through an article in the *Haemophilia Society* bulletin of May 1991. Ironically the article was written by Dr Charles Hay the haematologist attending to my husband.

The article (enclosed) was entitled Haemophilia and Liver Disease and was by-lined to Dr C.R.M. Hay, Director of the Mersey Region Haemophilia Centre.

The central thrust of the article, is to the effect that research, conducted over a number of years, had led to the medical conclusion that a serious hepatological problem lay in store for haemophiliacs, who had been injected with infected blood products.

The author clearly makes the distinction between NEWER and OLDER haemophiliacs. Clearly my husband fell into the OLDER category, especially as it was known that he had suffered from 'transfusion hepatitis' in the late 1970s and then again in November 1981, following transfusions accompanying a duodenal ulcer at the Royal Liverpool University Hospital.

There had clearly been some concern about the likelihood of a newer hepatological problem for haemophiliacs for some years and as Dr Hay noted in his 1991 article:

"Increasing awareness of transfusion hepatitis during the 1970s led to the universal adoption of hepatitis B testing of all blood donations and the closure of American skid-row blood banks. This greatly reduced the frequency of hepatitis B after transfusion, but had little impact on the prevalence of transfusion hepatitis as a whole, since it was usually caused by non-A non-B hepatitis.

"The hepatitis C test is only now becoming widely available after the discovery of the virus in 1989 and all blood donations will be tested for this virus within the next few months."

The article later concludes by stating:

"For newly diagnosed haemophilic patients, haemophilic liver disease is of historical interest only, since current licensed concentrates are virologically safe. For older patients, it is usually not an active concern since most will have recovered or will have mild liver disease.

"A minority of patients are at risk from more serious problems and may require treatment with alph-interferon (sic) however, even though the role of such treatment is still under investigation.

"Certainly, it is one of the functions of every haemophilia centre to monitor all patients for evidence of chronic liver disease and the clinical problems that can result from this."

Therefore, with some justification, my husband and I safely assumed, prior to his admittance for the 1991 knee operation, that such monitoring had been ongoing and in the absence of information to the contrary, that he was a suitable candidate for major surgery.

The dangers of major surgery in haemophiliacs are well known and it could be sensibly assumed that such dangers would only be compounded, especially in a haemophiliac suffering from chronic liver disease.

My husband's admittance for his knee operation is, I believe, proof that he was judged to be in an adequate hepatological state.

Medical record sheet No. 1382 (enclosed) dated October 7 1991 would appear to back this up.

A letter from Charles Hay, the Consultant Haematologist, to Prof. L Klennerman of the RLUH Orthopaedic Dept, refers specifically to the prevailing conditions governing my husband's admittance for a knee-replacement operation.

Dr Hay clearly states: "**There are no haemotological problems other than his haemophilia, so the whole thing should be very straightforward...**"

To be totally accurate there probably weren't any haemotological probelms but there most definitely were hepatological problems in existence and these most certainly were detectable.

The operation, finally carried out on December 6 1991 had clearly run into complications as early as the mid-point of January 1992.

It is now clear that those complications surfaced because such a complex operation had been carried out on a patient suffering from Hepatitis C.

Naturally extensive testing was carried out in January 1992 and on the 14th of that month, I was informed, by the RLUH, that my husband was suffering from CIRRHOSIS OF THE LIVER and it was explained to me that this had been the result of ongoing Hepatitis C (formerly non A non B), most likely the result of infected 'preheat treatment era' blood transfusions during his duodenal ulcer operation at the same hospital in November 1981.

At that point I was told that my husband's condition was terminal. His condition also explained as to why the knee-replacement had not been the success expected, and indeed I was told, that if it had been known, prior to the operation, that my husband was suffering from Hepatitis C / cirrhosis, then most certainly he would not have been allowed to undergo surgery.

I find this explanation difficult to reconcile with the extensive medical research into the likely incidence of complicated liver disease, especially in patients such as my husband.

It is difficult to accept that my husband's condition had not been monitored, especially when the haematologist in charge of him, namely Dr Hay, had carried out such extensive research and stated publicly that "it is one of the functions of every haemophilia centre to monitor all patients for evidence of chronic liver disease and the clinical problems that can result from this."

Indeed to compound the dissatisfaction with the explanation given me the RLUH, the contents of an article in *The Lancet,* of June 29 1985 (enclosed), to which Dr Hay was one of four contributing haematologists, make it doubly unsatisfactory that I learned about my husband's terminal condition at such a late stage.

The introductory summary of the article clearly states that:

"It is anticipated that liver disease in haemophiliacs will become an increasing clinical problem in the future."

It goes on to say that:

"Although few reports of death attributable to liver disease in haemophilia have appeared, we predict that this will become more common.

"The introduction of virus-free or synthetic factor VIII concentrates cannot be expected to make a significant impact for several years."

It is my contention therefore, especially in the light of such knowledge, that my husband's condition had not been monitored satisfactorily.

The key-point of proof here, I believe, was his admission for knee surgery in December 1991. Given that he was deemed to be suffering from chronic liver disease in the December, it is hard to believe that advanced cirrhosis had developed by the following 14 January - a little over a month.

Therefore it is my contention that his hepatological monitoring was grossly inadequate and as such, in my opinion, was a contributing factor in ongoing medical negligence.

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2)

Why, after diagnosis with cirrhosis of the liver in January 1992, followed by periods of oesophageal bleeding (varices), which are known indicators of the recognised medical state known as "liver failure" - the recognised starting point for consideration of liver transplantation - was all mention of such a possible procedure withheld until June 1994, when he was finally referred to a liver specialist for the first time in 2.5 years?

Having accepted, in good faith, in 1992 that my husband was suffering from cirrhosis of the liver, I enquired as to how long he would have to live. I was told by Dr Hay that his life expectancy would be "maybe 2 weeks, 2 months or 2 years - in fact, he may never leave this hospital."

No mention was ever made of a transplant or any other avenues of hope.

I was not given any supplementary information relating to the manifestations of his condition. Therefore, it was something of a shock, when the first bout of oesophageal bleeding (varices) occurred in April 1992.

My husband was admitted to the RLUH with the condition which is a known indicator of 'liver failure'. He was admitted to a high dependency unit and was in a life threatening condition for three days.

Only after he rallied and was discharged,was it that we were informed of the nature of VARICES and it was explained that from then on, he would need to undergo surgical treatment, on a regular basis, to counteract the spontaneous oesophageal bleeding.

We were, at no stage, informed that he was in the medically defined state known as LIVER FAILURE. However medical record sheet No. 724 (enclosed) dated January 16 1992, just two days after I was informed that he had Hepatitis C / cirrhosis of the liver, clearly states "liver failure".

Another sheet, No. 841 (enclosed) dated May 5 1992, again clearly lists "liver failure"

Yet not only was no mention of a liver transplant mooted, my husband incredibly was still not referred to a hepatologist.

It is my contention that clearly my husband should have been referred to a hepatologist quite some considerable time before December 1991. If not, however, then surely such action should have been taken in January 1992 following the diagnosis with Hepatitis C / cirrhosis. In the event of the abject failure to refer on either of those two occasions then quite clearly he should have been referred at the latest by April 1992 following the first varices attack.

It is known that varices is one of the classic indicators of 'advanced liver failure' and indeed the document *Hepatitis C - the facts* (enclosed) produced by the Haemophilia Society, in conjunction with Prof. Mike Makris, from the Royal Hallamshire Hospital, Sheffield, states thus.

Under the sub-heading *'Liver transplantation - when is a liver transplant considered ?'* the document states:

"Once there is advanced liver failure. Your doctor will discuss this with you if it is present. Features of liver failure include swelling of the abdomen (ascites), dilated veins (varices) in the gullet (oesophagus) which can rupture and cause vomiting of blood, or confusion (encephalopathy)."

It really is quite astonishing now to consider that my husband had reached such a stage and the possibility of a transplant was never mentioned. However it did not seem so to us at the time as the idea of a transplant had never crossed our minds as being even the remotest possibility in a haemophiliac.

It is even harder in retrospect to accept that my husband underwent two further very serious varices attacks - later on in April 1992 and then again in May 1992 and still the possibility of a transplant failed to materialise.

It is obvious to us now that such a possibility was not mentioned for the simple reason that my husband had not been referred to a hepatologist.

Only in the period after May 1992 were my husband's varices attacks controlled, by means of vein-strengthening injections (sclerotherapy), a procedure repeated at regular and frequent intervals until just 4 days before his death.

In the period between May 1992 (the control of the varices) and June 1994, in excess of two years, my husband's condition visibly deteriorated to the point where his quality of life was *nil*.

His medical records show repeated problems with a hernia, itchiness, leg ulcers, spontaneous and embarrassing tongue bleeds, ascites, acute digestive problems and chronic fatigue. All are known symptoms of advanced liver failure.

On a personal level, it was distressing for me to witness that by May 1994 my husband was longer able to wear formal clothes such was the distention of his abdomen. His only comfortable attire was loose-fitting leisure wear.

His social life, as a consequence, was completely indoors and was blighted by the tongue-bleed episodes. As a result, by that stage my husband and I were at a very depressed level such was his ongoing rapid debilitation and deterioration.

In June 1994 his condition had visibly worsened to the point where a referral to a liver specialist was medically inescapable.

It is to be noted though that medical record sheet No. 1425 (enclosed) dated June 8 1994, shows that Dr Ian Gilmore was consulted only on the advice of Mr Mark Hartley, a Senior Surgical Registrar in the RLUH Gastro' unit and not by the hematology department.

Pointedly Mr Hartley requests of Dr Gilmore:

"I would appreciate it if you could see him fairly soon in your clinic because of his discomfort."

It is important to stress here that at that point, it had not occurred to me or my husband that such, now seemingly obvious action, should have been taken at least two years earlier.

To our amazement and without any form of medical examination, Dr Gilmore immediately raised the idea of a liver transplant. In fact, Dr Gilmore, before even taking so much as my husband's temperature, informed us of exactly which hospital he wished my husband to attend - namely the Freeman Hospital, Newcastle. Consequently the process to transfer my husband to the north east began immediately.

It is my contention, that given that my husband was deemed a possible liver transplant candidate just four months before his death, that surely he should, in light of all the medical knowledge available at that time, have been considered for a transplant in January 1992.

I believe that the failure to refer my husband to a liver specialist for **TWO AND A HALF YEARS** is considerably evidential of medical negligence, especially when the idea of liver transplant was raised almost immediately upon doing so.

Serious questions must be asked as to how a University Teaching Hospital failed in such basically stark terms to a refer a patient, patently suffering with chronic liver disease, to a liver specialist for two-and-a- half years, when such a course of action would have seemed obvious even to the non-medically qualified.

---

3)
Why, in July 1994, when preparations were underway to send my husband to the Freeman Hospital, Newcastle, for further tests re: a liver transplant, was the existence of cancer not noted at the RLUH ?

It is medically known that the hopes for a liver transplant are seriously undermined, if not eradicated, by cancer. My husband's cancer, as can be proved, was in existence in July 1994 in the form of a 6.5cm (diameter) tumour with an Alpha-fetoprotein reading of 9280. Liverpool's failure to spot this crucial indicator was duly noted by the clinicians in Newcastle.

After consultation with our daughter and son, my husband decided, with some degree of heightened anticipation, to undergo preliminary tests for a liver transplant.

It needs to be stressed here that the whole idea of a transplant came as a complete shock to all of the family. Essentially though, it raised all our hopes by no inconsiderable measure. Not only would it have meant that my husband's life might be prolonged, maybe for another 10-15 years but also that such a life extension could be haemophilia free, thanks to a new liver.

The massive psychological leaps here cannot be understated. The feelings of euphoria were difficult to suppress although we knew we must do so, in case our hopes were dashed. Nevertheless, we had our own confidences that, at last, our hopes and prayers were being answered and the end to my husband's suffering could well be near.

It was therefore with some anticipation that we waited for transference to Newcastle.

Shatteringly though, in early August 1994, my husband underwent a serious bout of HEPATOLOGICAL ENCEPHALOPATHY. In much the same way as I was not informed back in April 1992 about the varices attacks, I was again subjected to a quite frightening episode, whereby my husband slipped into encephalitic coma overnight, without me realising or even suspecting a problem until a very advanced comatose state had developed.

At no stage since cirrhosis was diagnosed in January 1992 were my husband and I warned about the dangers of encephalitic coma episodes.

My husband's medical records confirm that his life was seriously threatened for several hours, until the coma was eventually treated at the RLUH following his admittance to the Accident & Emergency unit.

The hospital's records will confirm that in August 1994 the A&E dept was undergoing extensive reconstruction and was in a quite chaotic state. My husband, a haemophiliac, suffering from cirrhosis of the liver, and, unknown to us at that time - the end stages of liver failure - was left on a trolley for almost six hours, whilst myself and my family were asked rudimentary questions about his health, such as "is an asthmatic ?"

Had we have been informed of the likely incidence of coma, we would have been able to inform the overstretched A&E dept staff of the true nature of my husband's condition.

Once my husband's condition eased the next day, we were left to consider what remained of the transplant possibilities.

We were informed, rather confusingly, that my husband was now in the FINAL PART of the END STAGES of LIVER FAILURE. As far as we were aware, up to that point, my husband had not even entered liver failure.

It is clear to us now that liver failure had been in existence prior to the first varices attack in April 1992. From that point onwards, his liver had entered the "end stages" process - as highlighted by varices. Indeed those end stages were now coming to a conclusion with the onset of coma. Yet my husband had only been recommended for a liver transplant five weeks earlier.

Within five days of the coma episode, my husband and I were transferred, via hospital limousine, to the Freeman Hospital, Newcastle. It is fair to say that upon leaving Liverpool, facing the unknown in strange surroundings, that we were both in quite an emotional state.

It must also be stressed that a journey, which later proved to be utterly pointless, was a very tiring endurance for my husband. It is also distressing now to reflect that it was a sheer waste of precious days.

Tests with a view to a liver transplant started immediately and were progressing well on the following Tuesday, when the transplant coordinator explained to my husband, myself and our children, who had travelled north that day, the precise details of the operation.

We were given a step-by-step introduction to the whole process, even down to the point where we were told we would be receiving a bleep in order to let us know that a donor liver had been found.

Although it would have been quite impossible for my husband to have even considered a holiday abroad - it is interesting to note that the plans for a transplant had reached such a developed stage in Newcastle that we were told that under no circumstances must my husband leave the country.

It is fair to say then that the process of preparing for a transplant had reached an advanced and very detailed stage and it was accepted by all that if a donor organ became available then my husband would undergo procedure.

The whole family was very optimistic.

It was therefore with a sickening shock, the extent of which I cannot emphasise adequately, that my husband and I learned, just hours after watching our elated children return to Liverpool full of hope, that that transplant was an impossibility because a liver scan had revealed a tumour some 7cm in diameter.

It is important to record here that when the Newcastle staff were breaking the news to us, they pointedly asked my husband how long it had been since his last liver scan. When they learned that it had only been three weeks earlier in Liverpool, they seemed more than a little surprised.

However before breaking the shattering news to us, the clinicians at Newcastle had obviously discussed the likely impact. Quite naturally they were concerned about how we would react to such news so far away from home.

As shown in the Newcastle medical records Nos 1 and 2 (enclosed), dated August 18 1994, the clinicians in Newcastle at a prior stage deliberated as to whether they should inform us of the cancer.

It is clear from the clinical notes that Newcastle had decided to discuss the findings with Dr Gilmore at Liverpool and "we will simply say we have finished assessment and will let him know outcome."

However, it is clear that this decision was reversed at some stage during the day and later notes state that "COR has informed patient and his wife," and "suggested that surgery was probably not now and option..."

It was fortunate for us that Newcastle reversed their decision and informed us, as it is quite possible that my husband and I would never have discovered that the cancer was already in existence at the time of the previous liver scan in Liverpool.

The day following Newcastle's discovery, Prof. Bassendine's letter to Dr Gilmore (enclosed) dated 19 August 1994, confirmed the existence of the tumour during the Liverpool scan.

Detailing that my husband, as part of his work-up, had an NMR scan, Prof. Bassendine reports that Newcastle had discovered "a lesion of approximately 7cm in the left lobe, possibly penetrating the capsule".

Prof. Bassendine goes on to state: "On review of his Liverpool medical records we unearthed an alpha-fetoprotein from blood taken on 15th July of 9280, confirming that he has developed a hepatocellular carcinoma on the background of his Hepatitis C cirrhosis."

Interestingly I find that Prof. Bassendine's letter revealing Liverpool's failure to spot cancer was not in the medical records file submitted to me by the RLUH. My only access to this information came via the submission of records from the Freeman Hospital.

One is left to wonder why such an important document is missing. I also find curious the remark made by Dr Hay (August 26 1994) upon my husband returning to Liverpool, insisting that there was no cancer prior to Newcastle. Indeed Dr Hay, obviously referring to the gap between the Liverpool and Newcastle scans went on to say that "a lot can happen in three weeks."

However in the records submitted from Liverpool, Sheets 106 and 373 (enclosed) confirm Prof. Bassendine's report. Sheet 106 (a blood test, taken on 18 July 1994 - 20 days prior to the encephalopathy episode) clearly shows the Alphafeto Protein level of 9280. The only medical conclusion here is that my husband was suffering from cancer.

The consultant named was C.R.M. Hay.

It must be stressed also that in the document referred to earlier Hepatitis C - The Facts, it goes on to state (enclosed): **"For people with cirrhosis, an abdominal ultrasound examination and alpha-fetoprotein determination are recommended at approximately four month intervals."**

Worse though, is the liver scan result (Sheet 373, July 20 1994 - enclosed. i.e. subsequent to the revelation of the AFP level):

Dr GRO-D the Senior Registrar, reports to the named clinician, Dr I.T. Gilmore that the ultrasound has revealed "a very well defined round-mass (6.5cm in diameter) in the left lobe of the liver. This has no characteristic appearances and it is not possible to differentiate between a regenerative nodule and tumour."

At face value, this would appear to suggest that the RLUH is incapable of diagnosing cancer ? Even given the apparent identification problems, three things, in my opinion, point towards medical negligence / incompetence.

Firstly, given the medical knowledge available, the likelihood that the "very-well defined round mass..." (appearing on the the liver of a Hepatitis C suffering haemophiliac, with cirrhosis of the liver) was cancer must have been very high indeed and certainly worth consideration.

It is my firm conviction that the failure to refer my husband to a hepatologist until June 1994, the omission to explain about encephalopathy, the failure to diagnose cancer and the earlier refusal of a work-up, are all examples of ongoing medical negligence.

It is important to note that medical records 1433 and 1434, (both enclosed), which form a letter from Dr Hay to Prof. GRO-D at the Royal Hallamshire Hospital , dated 19 August 1994: Dr Hay concedes that my husband had undergone varices treatment for the last 18 months.
However, he goes on to report that my husband's "AFP have been negative and ascitic tap showed no abnormalities suggestive of underlying carcinoma". This was clearly not the case.

Interestingly Dr Hay then reports that "we have been considering hepatic transplantation with our hepatology for 2/3 months" and the delay in submission to Newcastle was down the the hepatologists "dragging their feet a bit".

It is difficult to understand as to what the purpose of this letter was, yet it clearly indicates that my husband's transference to Newcastle was too late.

Another record from my husband's file, medical record No. 1437 (enclosed), a letter from Dr Gilmore to Dr Hay, dated 20 October 1994, six weeks after my husband's death is difficult to comprehend.

Apart from the fact that it was Dr Gilmore who suggested that myself, my daughter and my son should meet him - the letter seems to indicate otherwise - it is difficult to see as to what purpose Dr Gilmore is pursuing. However, as with Dr Hay, Dr Gilmore seems to indicate that the timing of the decision to consider was husband for transplantation was far from satisfactory.

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4)

Why, on return to Liverpool on August 19 1994, with said tumour likely to be in excess, at that stage, of 7cm (diameter), was chemotherapy treatment not due to be administered until GRO-A 1994, which, as it transpired, proved to be three days after his death ?

This represents an unacceptable waiting period of 19 days for a patient with seriously defined cancer. My husband was actually discharged from the RLUH following treatment for varices just four days before his death.

Following my husband's return to Liverpool, after being diagnosed with cancer, it was accepted that chemotherapy would need to be administered as soon as possible.

It is unacceptable that my husband returned on 19 August 1994 and by the date of his death on 3 GRO-A 1994 he still hadn't received treatment. In fact his first chemotherapy session was not scheduled until 6 September 1994 - and may I stress that it was most disturbing to receive a telephone call from the RLUH on that day, informing me that my husband had failed to appear for his appointment.

It is difficult to accept that Newcastle were willing to keep my husband at the Freeman Hospital and commence chemotherapy treatment immediately whilst the RLUH did not consider it necessary for a further 18 days.

In Dr Hay's letter to Professor GRO-D (Medical Record No. 1433) , he refers to the "urgency" in sending my husband to Newcastle for transplant assessment. However, no such urgency is sensed in treating my husband for cancer, the eradication of which was the condition for a return to transplant assessments.

It is particularly unacceptable that on the Monday before my husband's death he was admitted to the RLUH for his varices to be treated. I was informed that it was the variceal check-up that forced the delay in chemotherapy as the oncologist only visited the RLUH once a week on a Tuesday.

A likely appointment for the commencement of chemotherapy on the Tuesday before my husband's death was cancelled by the variceal check-up which revealed no change in condition.

As the reports state, my husband had a level of AFP sufficient to suggest a serious cancerous growth on July 19th. yet by September 3 he had still not received any chemotherapy - a period touching on SEVEN WEEKS.

That seven week figure (at the inside) depends on my husband having achieved an AFP level @ 9280 in just one day, namely July 19. However, the likelihood is that my husband had started to develop cancer considerably earlier, which means that for the whole of the last three months of his life - and probably more - he was suffering from Hepatocellular Carcinoma and subsequently died without the relevant treatment.

I find that difficult to accept in the case of my husband, a patient who was so obviously in need of constant monitoring and who, ironically, spent most of that time in hospital.

I would refer you to the last appendices (enclosed) namely a copy of a letter, in my late husband's handwriting, detailing his general quality of life for Department of Social Security purposes and also supplementary letters of support for the authenticity of his condition from Dr Charles Hay and Mrs Linda Smith, Social worker for the RLUH.

I would stress the date of Dr Hay's letter particularly. December 1993 was still six months prior to any mention of a possible liver transplant. Yet the haematologist treating him lists all of the factors mentioned throughout this statement that are known prime indicators of liver failure.

Dr Hay makes a general point that my husband was in **"poor general health".** To say that was an understatement is an understatement in itself.

I also refer you to the significant correspondence (enclosed) from Dr I Gilmore to myself, 9 September 1994, following my husband's death, who when referring to the late possibility of a liver transplant, states that **"it was particularly disappointing that his hopes were rasied."**

I refer also to further correspondence from Dr Gilmore, this time to Dr Hay, 20 October 1994 (enclosed)in which he seems at pains to assert that the **"timing"** of the transplant would have been **"much easier"** had we have had a (liver) centre in Liverpool.

My contention is what difference did it make to the timing of a liver transplant whether we had a centre in Liverpool ?

I also refer you finally to the correspondence from Dr Hay to myself, 21 November 1994, (enclosed).

GRO-A

May 1997.

RECEIVED
-2 APR 2004

GRO-A
Liverpool,
GRO-A

Tel: GRO-C
E: GRO-C

Tim Cox-Brown,
Caseworker, Fitness to Practice Directorate,
General Medical Council,
Barnett House,
53 Fountain Street,
Manchester,
M2 2AN.

31 March 2004.

Your reference: TCB/FPD/2004/0781

Dear Mr Cox-Brown,

Re: Dr. Charles Richard Morris Hay (and Dr Ian Gilmore).

Thank-you for your letter of 29 March 2004, detailing the requirements for pursuance of complaint. You will also note that in addition to Dr. C.R.M. Hay, I have broadened the scope of this case to include also Dr Ian Gilmore, who in 1994 was a hepatologist at the Royal Liverpool University Hospital.

Accordingly, I enclose (by hand at Fountain Street) the following relevant documentation.

1. A completed, signed, consent form, referring to Drs Hay and Gilmore, giving my approval for the GMC to disclose matters of this case to those involved.

2.1 An outline summary of the case against Dr Hay.
2.2 An outline summary of the case against Dr Gilmore.

3. A broader summary, with relevant appendices, of the scenarios relating to the treatment of my husband (GRO-A) by Drs Hay and Gilmore, particularly relating to, but not restricted to, the period of December 6 1991-September 3 1994. This document was originally written in 1997, and was used as a statement of complaint as part of a medical negligence case, conducted through my solicitors (Irvings, Liverpool) at that time.

4. Copies of all my husband's medical records.

Yours sincerely,

GRO-C

GRO-A

Enc. All above.

GENERAL
MEDICAL
COUNCIL
Protecting patients,
guiding doctors

GMC Case Reference Number: **2004/0781**

Name of correspondent: **Mrs.** GRO-A

- Are you willing to identify the doctor? YES ☑ NO ☐
- Are you willing to allow us to disclose your letter to the doctor? YES ☑ NO ☐
- If necessary, would you be willing to be a witness at a public inquiry? YES ☑ NO ☐

Name of doctor/(s)

Dr. Charles Richard Morris Hay

DR. IAN GILMORE

Declaration

I have provided the GMC with details of the doctor(s) about whom I have written and confirm that the GMC may disclose to the doctor(s) my letter, including any supporting documents, and any further information I may send to the GMC in connection with this matter.

I understand that if I have answered no to any of the questions above, it is unlikely that the GMC will be able to take the matter forward.

Name (please print)... GRO-A ....

Signature GRO-C .... **Date**.......... 2 . 4 . 04 ....

1

The case against Dr C.R.M. Hay:

There is enough empirical evidence, stretching back to at least 1985, to suggest that Dr Hay was more than fully aware of the prevailing issues, that had faced, and were facing, the haemophiliac community in the UK from the period 1975-1994. Particularly, there is precise evidence to indicate that Dr Hay had a strong knowledge of one of the headline issues, namely the prevalence of progressive liver disease as it affected haemophilic patients, which, in 1985, he queried as to whether it was actually an 'understated' matter.

I contest, therefore, that a professional, operating with the benefit of such a solid base of clinical knowledge, should not have failed to foresee, or certainly recognise, the clinical manifestations of liver disease in my haemophilic husband (Mr GRO-A as they presented themselves - often visibly - throughout the period whilst he was under the haematological care of Dr Hay.

Throughout my husband's medical history from 1978 onwards, the instances of hepatic irregularity were writ large in his records. While it is accepted that Hepatitis C was not formally identified until 1989 - but had hitherto existed under the ambiguous heading of 'Hepatitis non-A, non-B' - it could be assumed, from my husband's medical notes prior to that date, that he was in a high-risk category of having been exposed to the virus through infected NHS blood products as administered to him at NHS hospitals in Liverpool. It is the case though that a test for Hepatitis C certainly existed from the mid part of 1991 - and most definitely prior to my husband's admission to the Royal Liverpool University Hospital (RLUH) for a knee replacement operation on December 6 1991. Such a test was never conducted on, or even considered for my husband, prior to that date, despite the extreme likelihood, certainly as far as the more knowledgeable members of the medical community would have undoubtedly suspected, that he would indeed have the virus.

It was only in the prolonged and confused aftermath of my husband's knee replacement operation, wherein his progress was minimal, that such a test was undertaken (and then only after my husband had to undergo another corrective procedure in mid-January 1992) to identify the source of his problems..

From about 18 January 1992, no later, it was identified that not only was my husband suffering from Hepatitis C (most likely contracted after being treated with contaminated NHS blood products at the RLUH during a duodenal ulcer repair operation in November 1981) but that the virus had progressed, unchecked, to the point where he was also suffering cirrhosis of the liver and, at this point, according to Dr Hay verbally, he only had some 2.5 years left to live (a remarkably accurate estimation given the eventuality).

Whilst I do maintain that Dr Hay had been negligent, in the round, to this point, for failing to assess the ongoing and indeed visible deterioration of my husband's health, especially in light of the expert knowledge and suspicions that he had long since externally professed, I hold that he was pointedly negligent thereafter.

Dr Hay should, at this point, at least have: 1) referred my husband to a hepatologist; 2) helped, either solely or in conjunction with a fellow professional, to prepare my husband and I for the likely manifestations of his hepatic state (such as varices episodes, which were first terrifyingly experienced, without preparedness, in April 1992); 3) unequivocally have informed my husband and I that he was already in the clinical phase known as 'liver failure'; and 4) recommended my husband for a liver transplant.

None of the above was achieved. Consequently, my husband and I were completely unaware what was happening, even as late as August 7 1994, when he underwent an, again unprepared for, hugely traumatic episode of encephalitis.

In eventuality, my husband was NEVER referred by Dr Hay to a hepatologist - at any point, which is both astonishing as well as being grossly negligent. My husband was only finally referred to such a professional - who transpired to be Dr Ian Gilmore - by a Dr Hartley, not Dr Hay. Subsequently, I was made privy, via a third party, who can be named if so desired, that Dr Hay vehemently protested against this referral to Dr Hartley, saying (although this might not be a verbatim account) 'what do you think you can achieve for this patient that I have already failed to?'

My husband was duly referred on to Dr Gilmore and, up until this point, I hold Dr Hay solely responsible for the negligence meted out to my husband over several years at the RLUH.

From that referral point on, I hold that Dr Hay was jointly responsible, with Dr Gilmore, for the calamities that ensued between the period June 20 1994 - September 3 1994, that saw my husband - as well as suffering that encephalitis episode - be referred to the Newcastle Freeman Hospital for a prospective liver transplant, only to be returned to the RLUH as an impossible case because tests had proved that he was already suffering from cancer (with an alpha feto protein level of 100,000), and also callously disregarded for emergency treatment in the final two weeks of his life.

Although it was barely believable that my husband had been sent to Newcastle for work-ups ahead of a liver transplant when he was clearly, according to his notes, suffering from obvious cancer, no time was wasted in directing him back, in NHS transport, without delay, to the care of RLUH, where my husband presented himself on Friday 19 August 1994 - as per instructions sent from Newcastle to RLUH - only for him to learn there was no bed for him. He was dispatched home.

Whilst visiting an oncologist (Dr GRO-D) on Wednesday 23 August 1994, I encountered Dr Hay in the corridors of RLUH, whereupon he expressed his sympathy to me regarding me husband's state but immediately and without request defended his position to me stating categorically that 'he certainly didn't have cancer when he left here (on Saturday 13 August 1994)'.

I found this self-serving, and unsolicited, defence of his, especially at a time when vital days at the end of my husband's life were being squandered, unpalatable and negligent in their tone, intent and delivery.

An ultimately pointless varices reparation procedure was then arranged, by both Dr Hay and Dr Gilmore, for my husband on Tuesday 30 August 1994, which frustratingly meant that any administration of chemotherapy could then not be undertaken until Tuesday 6 September 1994.

My husband then died from complications arising from the bursting of his tumour on GRO-A 1994, some two weeks and one day after he had been despatched from the Newcastle Freeman Hospital for emergency treatment. I hold both Dr Hay and Dr Gilmore negligent for the inertia demonstrated in this latter period.

My pain at that time was cruelly compounded on Tuesday September 6, when Dr Smith, unwittingly, contacted me to ask me where my husband was as he had not arrived for his chemotherapy appointment.

MEDICAL PROTECTION SOCIETY

Direct Line GRO-C
Direct Claims Fax GRO-C
Secretary Nicola Oliver (9.00 – 5.30pm)

Mr Tim Cox-Brown
Caseworker
Fitness to Practise Directorate
5th Floor St James's Buildings
79 Oxford Street
Manchester M1 6FQ

Our Ref: CL/GB/540234
Your Ref:TCB/FPD/2004/0781

28th May 2004

BY FAX AND POST – GRO-C

Dear Mr Cox-Brown

Re: Dr CRM Hay

I have been instructed by Dr CRM Hay to respond to your letter of 30th April 2004.

It appears that the General Medical Council has received a complaint from Mrs GRO-A GRO-A in respect of medical treatment received by her husband between December 1991 and his death in GRO-A 1994. In a letter to the Council dated 16th March 2004 GRO-A raises allegations of "medical negligence" against Dr Hay in relation to this treatment.

On the basis of these facts alone it is submitted that this case may not be referred to the Preliminary Proceedings Committee, as more than five years have elapsed since the events in question. I refer to Rule 6(7) of the General Medical Council *Preliminary Proceedings Committee and Professional Conduct Committee* (Procedure) Rules Order of Council 1988 (as amended) which clearly states that:

"An allegation of misconduct in a case relating to conduct may not be referred to the Preliminary Proceedings Committee under this rule if, at the time the complaint was first made to the Council, more than five years had elapsed since the events giving rise to the allegation".

The purpose of the five year rule in conduct cases is understandable - to avoid prejudice to the parties and to ensure fairness in the proceedings. It is recognised that a delay in bringing a case can have a significant detrimental effect on the cogency of the evidence available; there is an inevitable dimming of the memory so that a witness's recollection of events may become less reliable with the passage of time; contemporaneous documentary evidence may be lost or no longer available several years after the event. The intention of the five year rule therefore is ultimately to uphold the integrity of the Council's own investigations and procedures.

In this case the events in question took place over 10 years ago; the case comes firmly within the five year rule and therefore, according to the Order of Council, it may not proceed.

If, contrary to Rule 6(7) this matter were referred to the Preliminary Proceedings Committee it is submitted that Dr Hay's ability to conduct his defence would be severely prejudiced by the delay. When he received the Council's letter Dr Hay called for copies of the patient's hospital records. So far only a few have been produced but having reviewed those documents Dr Hay already suspects that some of the original records have now gone missing or are lost. This is unfortunate but not entirely surprising from a document management perspective. The patient's records were voluminous. He was a haemophiliac who had contracted Hepatitis C; he suffered from numerous medical problems and was under the care of a number of specialists at more than one hospital. The matter is still under investigation but it appears quite possible that a complete set of this patient's hospital records are no longer available, which would obviously prejudice Dr Hay in his defence.

In order to defend this case Dr Hay may also need to interview and obtain evidence from the other practitioners who had responsibility for the patient during the period in question. He will have to overcome firstly the hurdle of trying to locate and identify those practitioners (who may have left the hospitals concerned and moved on). Then he will be prejudiced by the fact that those witnesses' recollection of events will inevitably have faded over the intervening 10-13 years.

As regards his own evidence Dr Hay has some recollection of this patient but freely acknowledges that his memory of events which took place over 10 years ago will not be perfect. It is similarly submitted that the Complainant's recollection of events will have dimmed over time. Sadly, it may also inevitably be the case that Mrs GRO-A memory has been influenced by her husband's subsequent demise and possibly tainted by the "conviction" she now has, that he was the victim of medical negligence.

In the circumstances, I submit that Dr Hay's ability to conduct his defence would be severely prejudiced by the delay in bringing this complaint, and it would be inappropriate and inequitable to allow the matter to proceed.

The medical screener may wish to consider whether there is an argument that this case should proceed to the Preliminary Proceedings Committee on the grounds that "public interest requires this in the exceptional circumstances of the case", pursuant to Rule 6(8). In my submission, no such argument exists in this case. The complaint concerns the management and treatment of one patient only, and concerns specifically:

- Management of the patient's knee replacement operation in December 1991,
- Management of his liver cirrhosis from January 1992,
- Management of a hepatocellular carcinoma diagnosed in 1994.

On any view these matters are private and unique to the patient in question. They do not raise wider matters of public interest. Further, whilst the circumstances of GRO-A GRO-A death were no doubt sad, they were by no means exceptional.

In my submission there could be no justification for an exceptional referral of this case to the Preliminary Proceedings Committee under Rule 6(8).

Finally, the screener should take into account the facts that:

- As far as Dr Hay is aware, the Complainant did not pursue a complaint through the hospital complaints procedure at the time,
- The Complainant has already attempted legal action in respect of these events, which failed in the late 1990's.

The statement which [redacted] has provided in support of her complaint to the Council was originally made in 1997 in support of a claim for damages for medical negligence. Dr Hay understands that [redacted] had the benefit of legal advice and assistance in investigating that claim and that an independent expert report was obtained on her behalf. That expert report was never disclosed but it must be presumed that it was unsupportive of the Complainant's case because shortly afterwards the claim was discontinued. In fact formal civil proceedings were never issued.

It is noted that the Complainant has chosen not to share a copy of that independent expert report with the Council, presumably because it does not support her position.

Thus it appears that the Complainant has already had the opportunity fully to explore the issues in this case, and she has the benefit of an independent expert report (which she has not disclosed). [redacted] is now trying to open the same allegations and explore the same issues, through the General Medical Council. It is submitted that this is inappropriate and an unreasonable waste of the Council's time.

Dr Hay would like to make it clear that he firmly refutes all the allegations and criticisms made by the Complainant, and reserves all his rights to provide comments on the substantive issues if this proves necessary. As a preliminary issue however it is submitted that the screener should have regard to the five year rule and properly conclude that no further action can be taken, and this enquiry should be brought to an end.

Yours sincerely

[redacted]

Catherine Longstaff
Solicitor
Claims and Legal Services Division

RECEIVED
15 JUN 2004

Reference: TCB/FPD/2004/0781

GRO-A
Liverpool,
GRO-A

Tel: GRO-A

Mr Tim Cox-Brown,
Caseworker,
Fitness to Practice Directorate,
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Manchester,
M1 6FQ.

15th June 2004

Dear Mr Cox-Brown,

Re: Dr CRM Hay

I thank-you for your correspondence of 2nd June 2004 informing me of, and enclosing, the response of the Medical Protection Society, written 28th May 2004 and received by you on June 2nd 2004, in relation to the above doctor.

I acknowledge also your invitation to respond to that response by June 16th 2004 and confirm that this letter will form the structure of my comments. I understand that, subsequently, Dr Hay's counsel will be invited to comment further.

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1. By way of explanation as to the structure of this letter, I wish to stress that, purely for cohesiveness, I will respond to the points raised by Dr Hay's counsel,. Ms Longstaff, only in the order she presents and in no way should it be interpreted that I have addressed matters in order of priority.

Ms Longstaff states at the start of her response that my complaint is in respect of treatment received by my late husband 'between December 1991 and his death in GRO-A 1994'. Whilst I broadly agree with this, I do wish to emphasise that those bookended dates are purely for simplicity, in a massively complex wider matter, as I submit that the events within that period and the evidence that exists as confirmation, are sufficient enough to support my contention of medical negligence on the part of Dr Hay against my husband.

However, you will note from my earlier submission, and indeed on several occasions in this response, that it is often necessary to refer back to before that period, in order to contextualise matters. I reserve my right to do this, where it is both necessary and appropriate, and I do not wish it to be assumed that I am only to mention events between 1991 and 1994 to the exclusion of all else.

2. Ms Longstaff states:

On the basis of these facts alone it is submitted that this case may not be referred to the Preliminary Proceedings Committee, as more than five years have elapsed since the events in question. I refer to rule 6(7) of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (as amended) which clearly states that

"An allegation of misconduct in a case relating to conduct may not be referred to the Preliminary Proceedings Committee under this rule if; at the time the complaint was first made to the Council, more than five years had elapsed since the events giving rise to the allegation".

The purpose of the five year rule in conduct cases is understandable - to avoid prejudice to the parties and to ensure fairness in the proceedings. It is recognised that a delay in bringing a case can have a significant detrimental effect on the cogency of the evidence available; there is an inevitable dimming of the memory so that a witness's recollection of events may become less reliable with the passage of time; contemporaneous documentary evidence may be lost or no longer available several years after the event. The intention of the five year rule therefore is ultimately to uphold the integrity of the Council's own investigations and procedures.

In this case the events in question took place over 10 years ago; the case comes firmly within the five year rule and therefore, according to the Order of Council, it may not proceed.

While I can entirely understand Ms Longstaff's recourse to the 'five year rule', which she seeks to do throughout her response, as reason for non-referral - indeed I fully expected her to cite such, which was first drawn to my attention by yourself in your correspondence to me of 29th March 2004 and again on 30th April 2004 - I rather feel this is attempting to force the matter back a few steps.

I fully understood your explicit reference to the possibility that the five year rule might be invoked when it was first made by you and I appreciated also that the lengthy and comprehensive submission that I hand-delivered to your office, on March 31st 2004, might ultimately be in-vain, if the medical screener were to block its passage. As such, I was fully prepared up to that point to invest time in what I knew may eventually prove to have been a wasted exercise.

Consequently, you will appreciate how re-assured I was, following your correspondence on 30th April 2004, informing me that the medical screener, no doubt fully in possession of the rules governing referral, had, as quoted, decided that 'involvement is merited regarding your complaint about Dr Hay'.

To this end, I would now be very disappointed, especially after the formulation of this considered response to Ms Longstaff's submission, to learn that the matter is to stop here.

Furthermore, I can only assume the decision to approve referral of my case against Dr Hay to the next stage was made by the screener following an in-depth consideration of the evidence, particularly as the screener had, at the same time, decided that the extent of the investigation must be narrowed to Dr Hay (you will recall my initial request that this matter be wider). Therefore, it would be reasonable to assume that the screener has made a fully lucid decision to approve involvement so far in the case against Dr Hay.

Although I am not familiar with the rules of the General Medical Council, it is my lay assumption that this, no doubt necessary, hurdle has now been cleared; although, of course, I stand to be corrected. Therefore, my understanding is that Ms Longstaff's repeated appeals for the five year rule to be invoked are after the matter.

Nevertheless, regardless of whether my understanding is misplaced or not, it is my submission that whatever conclusion the screener initially reached, by agreeing to further the case against Dr Hay, should continue to prevail and influence the progress of this matter further, as I can only conclude that the considerable evidence I supplied was substantial enough to merit the case progressing thus far.

While I therefore reject Ms Longstaff's attempted invocation of the five year rule, I share her view that 'the purpose' of it is 'understandable' - as it seeks to 'avoid prejudice' and 'ensure fairness in the proceedings'. I wish to assure you, and, by proxy, Ms Longstaff and Dr Hay, that I too wish to avoid such prejudice and achieve such fairness. It is my view, though, that there is enough documentary evidence alone to ensure that, even if the five year rule were to be waived, a non-prejudicial and unquestionably fair investigation can easily be conducted.

Furthermore, I reject, completely, Ms Longstaff's contention that the 'delay' (although I suggest 'time lapse' is a more appropriate description) in bringing this case would have a 'significant detrimental effect' on the cogency of the evidence available. I can assure you that the powerfully convincing nature of the documentary evidence is such that it cannot be diminished, even minutely, let alone to any significant detriment, by any passage of time.

Equally, I wish to stress that there is no 'inevitable dimming of the memory' as far as my recollection of events is concerned; and in no way has the passage of time rendered my recollection of events any less reliable now as a decade ago. However, if Ms Longstaff is alluding to the possibility, but certainly not an 'inevitability', that witnesses other than myself may experience 'dimming of the memory', then again I can assure you the cogency of the documentary evidence available is more than enough to compensate for any human failings that may, or may not, occur.

Similarly, Ms Longstaff's, understandable, concerns that 'contemporaneous documentary evidence may be lost or no longer available several years after the event,' can easily be allayed. For, even if Dr Hay has struggled so far to obtain certain documents, it is somewhat of a relief, especially in light of the need to achieve a fair and unprejudiced investigation, to remind you that a full set of my husband's medical records does exist, a copy of which is currently in your stewardship at Manchester, as obtained by me several years ago.

Nevertheless, Ms Longstaff makes a valid point, for I have always been able to ascertain, rather than merely suspect, that some documents were indeed missing from my husband's files - even at such a relatively early stage of acquisition by me. But these were so few as to be actually more conspicuous by their absence rather than their absence blurring the overall picture of my husband's case. For example, the results of repeat liver function tests and of an alpha feto protein test, requested on March 10th 1993, by a medic other than Dr Hay (namely Prof. Shields), which may have proved my husband had cancer far earlier than suspected (see several later references in this letter) have never appeared in my husband's files, despite my relatively early acquisition of his records. Nevertheless, it has always been something of a relief to me - and to Ms Longstaff and Dr Hay now, no doubt - that a fully illustrative picture of the management of my husband can still be drawn from the copious notes that do remain.

Having said that, it was a deep concern to me several years ago that those few certain documents relating to my husband were clearly missing and it is even more disconcerting now to learn, from Dr Hay's experiences, that the reverse is actually now true and so few of them remain lodged where they should be.

So, whilst I support Ms Longstaff's reported view, if it is correct and I have no reason to doubt it, that the 'intention' of the five year rule is to 'uphold the integrity of the Council's own investigations and proceedings,' I wish to assure you that the waiving of the rule, in this instance, is entirely safe, especially based on the cogency of the documentary evidence still available.

I note with interest, though, the absolute tone of Ms Longstaff when she submits that this case, according to the Order of the Council, 'may not proceed'. If this matter were as *fait accompli* as is presented by Ms Longstaff, then I would have fully expected her to end her submission there and then. However, I note that Ms Longstaff continues her submission to quite some considerable length and I am left to query as to why. I can therefore only assume that the rules of referral are not as absolute as Ms Longstaff makes out and a facility to override the five year rule, when it is deemed appropriate, does exist.

I wish to re-affirm my contention, then, that this is just such a case in point and re-iterate that, whatever judgement was made earlier by the screener, in order to let the matter proceed thus far, should continue to prevail and influence its progression.

3. Ms Longstaff states:

If contrary to Rule 6(7) this matter were referred to the Preliminary Proceedings Committee it is submitted that Dr Hay's ability to conduct his defence would be severely prejudiced by the delay. When he received the Council's letter Dr Hay called for copies of the patient's hospital records. So far only a few have been produced but having reviewed those documents Dr Hay already suspects that some of the original records have now gone missing or are lost. This is unfortunate but not entirely surprising from a document management perspective. The patient's records were voluminous. He was a haemophiliac who had contracted Hepatitis C; he suffered from numerous medical problems and was under the care of a number of specialists at more than one hospital. The matter is still under investigation but it appears quite possible that a complete set of this patient's hospital records are no longer available, which would obviously prejudice Dr Hay in his defence.

I can only assume that the considerable continuation of Ms Longstaff's response is an indicator that she is fully aware that the matter can progress and, indeed, her view that it could be referred despite, in her words, being 'contrary' to Rule 6(7), is a further implicit indicator, not only that such a facility exists, but that she is also aware it does.

Again Ms Longstaff suggests that Dr Hay's 'ability to conduct his defence would be severely prejudiced'. Whilst I can certainly appreciate Ms Longstaff's anxieties, I can only again emphasise that evidence exists of such a magnitude that it would eradicate any concerns that the unfortunate time lapse - but certainly not a delay - might diminish fairness.

It is re-assuring to learn that Dr Hay sought recourse to my husband's medical notes; I would expect this to be so. Having said that, I find it wholly inadequate that Ms Longstaff has felt it appropriate, *at this point*, to submit Dr Hay's, presumably considered, submission, having only read 'a few' of the documents that 'have been produced'. As is learned later in Ms Longstaff's response, Dr Hay is refuting all the allegations made against him. Whilst this comes as no surprise to me, it is a standpoint which I find impossible for him to maintain and, in any case, one which he would readily abandon as, despite any 'dimming of the memory' that he may or may not experience, documentary evidence will show his position to be baseless. Therefore, I find it shocking that Dr Hay is content enough to continue his intransigence having admitted to only reading 'a few' of the documents, as though that were enough to trigger Ms Longstaff's response. I can only interpret this most negatively. I find it arrogant. It is clear to me that Dr Hay does not think this matter serious enough to warrant further investigations *prior* to his counsel submitting a response. It rather smacks of hoping a swift response ensures the matter gets swept under the carpet before tedious concerted efforts are expended.

I would have hoped, at this stage, that I would not be having to address half-measures or conjecture; so it is with some frustration that I learn that not only has Dr Hay made his response on the reading of a only 'a few' documents but that he 'already suspects' that some are 'missing' or 'lost'. The realm of suspicion is not something I regard appropriate to a case of such import and I find it insulting that Dr Hay sees fit to deal, even at this point, in speculation. At this point in proceedings, it is my submission that to merely 'suspect' documents are missing is not adequate enough. On what grounds are such, quite disconcerting if true, suspicions made? Are there some documents missing or aren't there? Which documents are they? How can Dr Hay possibly identify them in their absence - especially after such a passage of time? What is it that leads Dr Hay to form his suspicions?

I agree, once again, with Ms Longstaff's view that it is 'unfortunate' that, as it appears, at least based on mere suspicion anyway, that some documents are missing; and I can only again re-assure you that such fears can immediately be allayed. However, I find it deeply disconcerting, on a broader point, how easily and blithely Ms Longstaff seems to accept the assumption that some documents are missing and I find it disturbing that her viewpoint, whether formed through instinct or experience, of the document management procedures at the NHS, is clearly so dim.

I wonder how it is, though, that Ms Longstaff *knows* my husband's medical records were 'voluminous', when, in fact, only 'a few' have been produced? I can only assume it is instinct - perhaps based on the complexities of my husband's condition - which tells Ms Longstaff that my husband's records were likely to have been voluminous; for, of course, she couldn't know this as fact from knowing that only a 'few' have been produced. It is her factual statement, despite suspicions that some documents are missing, that they were indeed so voluminous, which I find curious. Either she knows them to be voluminous or she doesn't? Surely it should be more a case that she can only 'suspect' them to be voluminous? It appears though that Ms Longstaff *knows* them to be voluminous - and it is indeed a correct assertion - but I find it somewhat contradictory that she can factually reach this conclusion in light of only 'a few' records having been located.

I also find it not a little disingenuous of Ms Longstaff to state that my husband was 'under the care of a number of specialists at more than one hospital'. Aside from the fact that I don't understand how she can make such a statement on the basis of only 'a few' documents having been located (and as Ms Longstaff has stated, we are referring, in the main, but not exclusively to, the period 1991-94), this is a gross distortion of facts.

It had been the case from the middle of the 1980s, almost exclusively, that my husband was under the care of Dr Hay at the Royal Liverpool University Hospital (RLUH) only. Indeed, since my husband was referred from Broadgreen Hospital, in November 1981, to the RLUH, for an operation to repair his duodenal ulcer (during which, it is roundly suspected, he contracted Hepatitis C from infected NHS blood products), he was never again an in-patient at another hospital until three weeks prior to his death - and then only for five days.

Furthermore, aside from necessary instances during the period immediately following his knee repair operation, in December 1991, in the aftermath of which his Hepatitis C positive status and his cirrhosis of the liver were diagnosed, for example the temporary involvement of orthopaedic professionals, my husband was under the constant care of Dr Hay from the mid-1980s to April 1992. Only then, in April 1992, when my husband suffered his first bout of varices - which, despite the existence, in any case, of cirrhosis, are a recognised indicator, certainly in someone like my husband, of liver failure - was my husband managed by someone other than Dr Hay, namely the gastro unit at the RLUH. Then, aside from recorded episodic instances of varices repair treatment, between April 1992 and June 1994, my husband was in the continuous and arch care of Dr Hay, until, at evidently too late a stage in June of that year, Dr Ian Gilmore was brought in.

As I have submitted in earlier correspondence, Drs Hay and Gilmore could then be assumed to be in the joint care of my husband, certainly only at the RLUH, until he was dispatched to the Newcastle Freeman Hospital - despite evidence to prove that he was already suffering from cancer, with an alpha feto protein taken three days later showing a reading of >100.000 micrograms per litre - for work-ups ahead of a prospective liver transplant. As stated, my husband was in the care of the medics at Newcastle for only five days until he was dispatched back to the RLUH as being so evidently unfit to travel, let alone to undergo a liver transplant.

Therefore, to put things into clearer perspective than Ms Longstaff does, my husband was under the care of the RLUH from the mid-1980s until his death in GRO-A 1994, except for a five day period. Also, within that period, my husband was unquestionably in the care of Dr Hay. Dr Hay also held a veto on the management of my husband. An example of this veto is given by Dr Hay's overriding of Professor Shields, in June 1992 - some six months after Hepatitis C and cirrhosis of the liver were diagnosed and within two months of my husband's first varices episode - when he actively blocked elective tests, as suggested by Professor Shields, to conduct a 'full liver work-up'. This episode even saw my husband actually being admitted to the RLUH on June 7th only to be sent home the next day after receiving apologies from Prof. Shields' team for the inconvenience caused. My husband's medical notes show that Dr Hay was not happy for this liver work-up to be conducted, despite the known extent at that time of my husband's worsening liver disease.

Only in the final three months of my husband's life could Dr Hay realistically contend that he shared care responsibility with another specialist and that was Dr Gilmore.

Therefore, Ms Longstaff's contention that my husband was under the care of specialists other than my husband - which although it could be borne out on a pedantic technicality if Dr Hay sought to be so obstructive - is a tenuous submission and far removed from the reality of the situation.

Dr Hay knows that my husband was almost constantly under his care for a significantly prolonged period from the middle of the 1980s until his death in 1994 and to suggest otherwise - especially 'at more than one hospital' - is a gross distortion which is obviously borne out of an intention to deflect blame; a tactic which, as you will see later in this response, in the shape of his letter to Prof. GRO-D Dr Hay has arguably sought to use before.

The inherent irony in Ms Longstaff's statement is such that I could only have wished that my husband were indeed in the care of more than one specialist, as it may have ensured that his hepatic state wasn't allowed to deteriorate to the state of cirrhosis, varices and beyond, before he was finally referred to a hepatologist and then not even at the behest of Dr Hay.

May I just again, at this point, re-emphasise these incontrovertible facts; namely that: between 1989 and 1992 Dr Hay failed to monitor my husband's hepatitis status; also that, after overseeing the diagnosis of Hepatitis C and cirrhosis of the liver on my husband, in January 1992, Dr Hay singularly failed, at any point prior to his death 33 months later, to refer his patient to a liver specialist; during this period, Dr Hay also wilfully obstructed a full liver work-up from being conducted on my husband; also the fact that my husband was finally referred to such a liver specialist (Dr Gilmore) in June 1994 was only at the behest of another medic.

Had it simply not occurred to a man who was internationally recognised as an expert in haematology and the hepatic irregularities that had beset the haemophiliac community, that his patient, whose notes, stretching back several years, confirmed bouts of Hepatitis A and B and a recording of Hepatitis Non-A, Non-B, who, in any case, went on to be diagnosed with Hepatitis C, then to develop cirrhosis of the liver, varices, and pronounced aescites, and many other complications besides, was in the need of a liver specialist? It simply didn't occur to him? A trained medical professional? Really? Sadly, it would appear so and I readily submit these base facts alone as among the central tenets of my submission of sustained medical negligence on the part of Dr Hay in his care of my husband.

I am at least re-assured that the apparent disappearance of my husband's medical records is 'still under investigation' but wish to stress that there need be no further fear that a complete set of my husband's records are no longer available. In any case, a full set of these records is held at your offices and therefore any anxieties Ms Longstaff has that Dr Hay's defence would be prejudiced on the grounds of lost evidence can, fortunately, be allayed.

4. Ms Longstaff states:

In order to defend this case Dr Hay may also need to interview and obtain evidence from the other practitioners who had responsibility for the patient during the period in question. He will have to overcome firstly the hurdle of trying to locate and identify those practitioners (who may have left the hospitals concerned and moved on). Then he will be prejudiced by the fact that those witnesses' recollection of events will inevitably have faded over the intervening 10-13 years.

I would not dispute that Dr Hay may need to interview and obtain evidence from other practitioners - however any emphasis that they would have held 'responsibility' for my husband is entirely rejected. This is purely a matter for Dr Hay and his counsel to decide. However, it would be my instinct that such practitioners, given the time passage that Ms Longstaff is so acutely aware of, would immediately seek recourse to my husband's medical notes as evidence. I have stressed earlier that this body of documentary evidence is of such quality that it would render any personal recollections as purely supplementary. However, if Dr Hay is keen to acquire such evidence then that, of course, is his right, to which I have no objection.

Nevertheless, I feel it to be rather overstating the case, to some significant degree, to allege that Dr Hay will have to 'overcome...the hurdle' of contacting and identifying those practitioners. I would submit that, in a highly networked world, with a rich choice of communications tools at our disposal, there will be little trouble in locating these practitioners and any assertion that there would be is wholly rejected. In any case, the matter of 'identification' is easy, as the case notes of my husband clearly name the practitioners who were party to - but by no means responsible for - my husband's care. I would indeed be very much surprised if some of the practitioners hadn't moved-on, as Dr Hay himself did very shortly after my husband's death, but again I submit that it is a relatively straightforward exercise, and certainly not a hurdle to overcome, in order to locate these people.

I also dispute the absolute tones of Ms Longstaff when she submits that Dr Hay will be prejudiced by 'the fact' that those witnesses' recollection of events 'will inevitably have faded'. It is neither fact nor an inevitability that these witnesses will experience memory 'fade'. They might. They might not. It is not, though, a fact that they have or will. In any case, it is again my submission that this concern too can be easily allayed given the quality and the extent of the materials available as evidence.

5. Ms Longstaff states:

As regards his own evidence Dr Hay has some recollection of this patient but freely acknowledges that his memory of events which took place over 10 years ago will not be perfect. It is similarly submitted that the Complainant's recollection of events will have dimmed over time. Sadly, it may also inevitably be the case *that GRO-A memory has been influenced by her husband's subsequent demise and possibly tainted by the "conviction" she now has, that he was the victim of medical negligence.*

It is deeply disappointing to learn that Dr Hay only has 'some recollection' of my husband, a man who, after all, was in his care for so very long, and suffered a multitude of traumatic complexities at a time when the events that were unfolding throughout the haemophiliac community were truly shocking. Nevertheless, I have to accept that such is the case, and that the gravity and tragedy of my husband's suffering were not of such depth that they became indelible in the memory of his carer. I am, at least, grateful that Dr Hay, despite the evidently erosive effects of a decade, has 'some recollection' of my husband.

Accepting that reality, however reluctantly, in no way indicates that I too am suffering from faded memory concerning the events that led to my husband's untimely death. I emphatically reject, and am deeply insulted by, Ms Longstaff's submission that my recollection of events has dimmed over time. I can assure Ms Longstaff that the tragedy that lay behind my husband's death was of such magnitude and distress that even the minutiae of events between 1991 and 1994, if not earlier, are seared into the memory of myself and my two children, who were grown adults at the time.

For a decade now, I have had little choice but to regularly revisit the precise details of my husband's case - and indeed was doing so very shortly after his death - and so I can assure Ms Longstaff that my recollection and knowledge of those events has actually deepened rather than shallowed. I utterly reject Ms Longstaff's iteration that my recollection 'will' have dimmed. It is another instance of Ms Longstaff passing conjecture off as absolute fact. Yet even were it the case that Ms Longstaff had modified her language to instead submit that my recollection 'may' have dimmed, I can assure you, most categorically, that it has not.

Insulted as I am by Ms Longstaff's earlier phrase, it is nothing compared to the repugnance I feel at her clumsily phrased submission that my memory may inevitably have been influenced by my husband's 'subsequent demise' (read death) and 'possibly tainted by the "conviction",' I have that he was a victim of medical negligence.

I wish to stress at this juncture, to the parties involved in this case, that they should not lose sight of the tragedy and trauma I have had to endure for over a decade now. Ms Longstaff's choice of language and questionable punctuation emphases are unwarranted in this case. Aside from the fact that I reject her crass submission - again if only because the medical evidence is sufficient to back up my claims even were my lucidity to be questioned - I would request that whichever way this matter progresses, a degree of tonal respect is appropriate in general submissions.

6. Ms Longstaff states:

In the circumstances, I submit that Dr Hay's ability to conduct his defence would be severely prejudiced by the delay in bringing this complaint and it would be inappropriate and inequitable to allow the matter to proceed.

I believe I have amply outlined that any such fears Dr Hay has about his ability to conduct an unprejudiced defence can be completely allayed. Furthermore, I reject Ms Longstaff's assertion of inappropriateness and inequitability and submit that it actually would be inappropriate and inequitable for this matter not to proceed.

7. Ms Longstaff states:

The medical screener may wish to consider whether there is an argument that this case should proceed to the Preliminary Proceedings Committee on the grounds that "public interest requires this in the exceptional circumstances of this case", pursuant to Rule 6(8). In my submission, no such argument exists in this case. The complaint concerns the management and treatment of one patient only, and concerns specifically:

- *Management of the patient's knee replacement operation in December 1991,*
- *Management of his liver cirrhosis from January 1992,*
- *Management of a hepatocellular carcinoma diagnosed in 1994.*

On any view these matters are private and unique to the patient in question. They do not raise wider matters of public interest. Further, while the circumstances of GRO-A *death were no doubt sad, they were by no means exceptional.*

I was not surprised that Ms Longstaff recoursed to the 'public interest' and 'exceptional' requirements of the Council's rules on referral. You will recall that in your correspondence of March 29th you enclosed a general synopsis of the Council's scope of powers and interest. Aside from the fact that I will go on to demonstrate the exceptional nature of my husband's case, if, in fact, I haven't already done so, it was the fulfilment of 'public interest' that I paid particular attention to.

Consequently, I gave due and appropriate consideration to this aspect before furthering my submissions to you. Subsequently, I made reference to the fact that Dr Hay, since the mid-1980s at least, has been held in high regard across the international haematological community for both his perceived expertise in this field and also where it has tragically overlapped, over the last two decades, with the hepatological field, most specifically because of the consequential hepatic irregularities experienced by haemophiliacs in the wake of being infected by contaminated NHS blood products.

To substantiate this submission I use two examples.

Firstly, you have in your possession a copy of a medical paper, written for The Lancet, 19 years ago by Dr Hay, in a period when the medical realities of HIV, let alone HCV, were still emerging. It was even less appreciated, in the round anyway, how these diseases would affect the haemophiliac community. Regardless of the nascent general understanding of such matters at that time, Dr Hay, when writing for The Lancet, demonstrated considerable foresight, knowledge and expertise, not only in the field of haematology but also in hepatology with particular reference to haemophiliacs and the likelihood that many of them will have contracted HCV as a result of treatment with contaminated products. In fact, as you will see, Dr Hay further demonstrates his awareness and concerns of this matter to the extent that he saw fit to title-headline the article with the query that the problem, as it was perceived in 1985, was actually an 'understated' one.

It is reasonable to assume that in the wake of this article, if not before - which in actual fact has proved remarkably, if tragically, prescient - Dr Hay's adjudged standing in his respected field rose considerably.

It is therefore with a sense of deep irony, frustration and no little concern, that I now am forced to review Dr Hay's management of my husband, from some six years after that article was written, and in a period which post-dated, by two years, the clinical identification of Hepatitis C, as opposed to its previous ambiguous standing as Hepatitis Non-A, Non-B. How, if it wasn't an oversight on a scale of such frightening magnitude that it could only constitute negligence, did a respected expert such as Dr Hay fail to notice, under his own care, a manifest portrayal, in the shape of my husband's complexities, the very things that he had forewarned of some six years earlier?

This alone merits an inquiry into negligent management. Also, it singularly demonstrates, not only the need for such an investigation on the grounds of both equitability and appropriateness, but also that the public interest demands it, so exceptional were the circumstances of my husband's fatal decline over a period of not less than 35 months leading up to September 1994.

Did it simply not occur to this leading field expert, that his patient, of whom he now only has 'some recollection', might be suffering from chronic liver disease? How, also, is it that, six years after Dr Hay wrote that article, he could also write, in my husband's medical notes - in the wake of his Hepatitis C and cirrhosis of the liver being diagnosed following his knee repair operation in December 1991 - that had he known of the 'severity' of my husband's hepatic state that he wouldn't have considered him suitable for such surgery?

Following this, how, also, was it that such a professed expert, then knowing his patient to be suffering from both Hepatitis C and related cirrhosis of the liver, singularly failed to refer him to a liver specialist at any point? Further, how was it that, as is shown in the case notes, this expert, being fully cognisant of his patient's chronic liver deterioration, which had further manifested itself in the shape of varices and aescites, wilfully obstructed the acquisition of advanced hepatological information, even when this was recommended by his collegues as being appropriate in the shape of a full liver work-up in June 1992, some two years before my husband was eventually referred, evidently too late, for a liver transplant?

Even further, how was it that such an expert, even knowing his patient was suffering so much that he was eventually, and terrifyingly, rendered comatose - without any forewarning as to the possibility - due to an episode of encephalopathy, failed at least once, and possibly twice, to recognise clinical indicators in the shape of positive alpha feto protein readings which clearly showed him to be suffering from liver cancer and therefore so obviously unfit for a liver transplant?

It is my submission that Dr Hay failed at every single critical juncture in the management of my husband. He either did so wilfully, in which case negligence would be starkly clear, or he did it out of incompetence, which again would lead to negligence. There can be no other conclusions. For such an esteemed expert to oversee even one of the above related episodes, before then correctly seeing his error and referring his patient to an appropriate specialist, would be considered negligent. But for it to happen repeatedly, even when there was a chance to refer him on, thanks to a colleague's recommendations, over such a protracted period of time, would defy belief were it not true.

The case for this matter to be referred on the basis of it being 'in the public interest' is therefore clear.

Among questions that must be asked are:

Was Dr Hay's management of my husband typical of his care of others? If it wasn't, then why was my husband so unequivocally overlooked time and again? Further, although he has only 'some recollection' of this patient - which I simply believe not to be true - would Dr Hay manage him so again, given the chance? If not, then why was my husband managed so?

Secondly, I make reference to the book 'A Case of Bad Blood' (Author - Rosemary Daly; Poolbeg, published 2003) which examined the tragedy that befell the Irish haemophiliac community following treatment with contaminated health service blood products.

Referring to the ongoing efforts of campaigners, particularly the Irish Haemophiliac Society (IHS) for whom the author worked, to raise public awareness of this tragedy, the book states on Pg 83-84 of the 2003 paperback edition:

In 1989, the Non-A Non-B virus was finally isolated and identified. As they already had hepatitis A and hepatitis B, the scientific community named it hepatitis C. We were taking more of an interest in it by this stage and seeking information where we could. In October 1989, we used our AGM as an opportunity to invite a UK expert on hepatitis (sic), Dr Charles Hay. He said, in his view, the hepatitis C virus was so closely associated with concentrated clotting-agents that most people with haemophilia had contracted it after their first injection.

I can only assume, although I stand to be corrected, that this is the same Dr Charles Hay as is being referred to in my submission.

It is clear then that, in the years since he wrote his paper for The Lancet, in 1985, Dr Hay was still not only taking a sustained and studied interest in the hepatological state of haemophiliacs but that his public reputation as an expert on such matters, both in the UK and beyond, was strengthening.

At the time of his attendance at that AGM in Ireland in 1989, if the author's version is accurate, my husband was under the direct care of the esteemed Dr Hay. Instead of finding himself fortunate to be in the care of such an expert, it would appear that my husband failed to benefit, repeatedly, from his carer's, presumably considerable, expertise.

It is clear then that either Dr Hay, given his management of my husband, didn't warrant to be held in such high esteem - in which case the public interest demands an explanation; or, in fact, Dr Hay was indeed deserving of such stature but he somehow failed to translate his knowledge into care regarding my husband. Either way, it is clear that an investigation is warranted on the grounds of public interest.

As an adjunct at this point, it is also interesting to note that the paragraph immediately subsequent to the referral to Dr Hay in 'A Case of Bad Blood', relates how the IHS 'brought in another expert', Prof. GRO-D to discuss developments. I only make reference to this as it was ironic that it was to GRO-D that Dr Hay pointedly wrote, on 18th August 1994, a day after my husband had been diagnosed with liver cancer at the Newcastle Freeman Hospital, and also, no doubt, as my husband and I were having to travel south, back to the RLUH trying in vain to absorb the devastation of the previous 24 hours. I include, for your ease of reference, the full transcript of Dr Hay's letter.

(19 August 1994) *Dear* GRO-D

Re: GRO-A

Diagnosis - *Severe haemophilia*
Hepatitis C
Decompensated cirrhosis of the liver
Oesophageal varices
Hepatocellular carcinoma

I am just writing to you about this patient for information. GRO-A *is one of three haemophiliac brothers, the other two of whom were HIV positive and died of AIDS.*

GRO-A *has been known to have cirrhosis for some time, and we have been injecting his varices quite successfully for the last 18 months.*

His aescites has developed over the last year, and was quite easy to control until very recently.

Alpha feto proteins have been negative and an aescitic tap showed no abnormalities suggestive of underlying carcinoma.

We have been considering hepatic transplantation with our hepatologists for two or three months in view of his deteriorating quality of life, and my general feeling that his prognosis was poor and they had been dragging their feet a bit.

He was admitted with his first episode of hepatic encephalopathy only 10 days ago and his aescites was even more difficult to keep under control, at which point (I was on holiday), they finally sent him up to Newcastle for urgent assessment for liver transplant.

They have just sent him back and tell us that he has hepatic cellular carcinoma. We are planning cytoreductive chemotherapy, following which they will reconsider him for transplantation.

I am sure this is a complication we shall see more of, but since the numbers are currently low I felt I should let you know.

It is ironic that I received this bad news while going through Mike Makris' thesis!

With best wishes - yours sincerely

Charlie

pc: Dr P Giagrande, Oxford.

You will note that Dr Hay, understandably, places my husband in the immediate context of being one of three haemophiliac brothers - all of whom were cared for by Dr Hay, and all of whom were wiped out through either AIDS or HCV following treatment with contaminated blood products. It is no surprise that Dr Hay should contextualise as such. At the time, the tragedy of my husband and his brothers, as their deaths unfolded over a five year period from 1989, was a well referenced case in the medical community. Since the death of my husband, the case of 'the three brothers', as it is often referred to, has been quoted across many national media outlets and indeed has been referred to in both Houses of Parliament. I only make this reference to put further into perspective Ms Longstaff's contention that Dr Hay only has 'some recollection' of my husband, which I don't believe to be the case.

You will also note that Dr Hay asserts that my husband's alpha feto protein levels 'have been negative'. Given that my husband had already been dispatched back to the RLUH from Newcastle Freeman Hospital with an alpha feto protein reading of >100.000 micrograms per litre, I find it incredulous to read Dr Hay's assertion. I also wonder what his motivation was for saying so, at that time, especially only some 24 hours - at the very most - after he had learned that my husband had cancer? Surely it would have been more useful for Prof. GRO-D to be informed of my husband's current alpha feto protein levels, rather than the totally ambiguous assertion that they 'have been negative'? What timescale is Dr Hay putting on this? Is he, in fact, still asserting that they 'have been negative' up to the point of writing?

In actual fact, my husband already had an alpha feto protein reading of 9280 over a month before Dr Hay wrote that letter, as the medical notes will confirm.

As you will also see from another transcript of a verbatim letter that I am enclosing in this submission, the alpha feto protein level reading of 9280 was only first unearthed by the medics at Newcastle, after it had lain unnoticed in my husband's file for five weeks. By any standards this is incredible, and it is especially so considering that, even after learning my husband had cancer, Dr Hay was still asserting that my husband's readings 'have been negative'.

I have emphasised before, in my earlier submissions, that shortly after returning from Newcastle, Dr Hay verbally informed me that my husband 'didn't have cancer when he left here' (the RLUH, on 13th August 1994). No doubt Dr Hay will have no recollection of such a conversation, although I can assure him that it took place in the corridors of the RLUH. Furthermore, any dispute that this conversation ever took place would likely be an issue to which Ms Longstaff would no doubt readily cite in support of her contention that Dr Hay's defence would be prejudiced on the grounds of 'dimming of the memory', consequent to a time lapse of 10 years.

Similarly though, it is also an evidential point to emphasise that such, in this case accurate, recollections only need be supplementary, simply because enough documentary evidence exists to show that Dr Hay, in the shape of his letter to Prof. GRO-D was clearly at pains to let it be, falsely, known that my husband's alpha feto protein levels were negative around the time of his transfer to Newcastle.

I submit that this is just one of scores of vignettes relating to my husband's case that can adequately demonstrate how the continuing cogency of documentary evidence, over and above personal recollections, flawed or otherwise, will certainly ensure a non-prejudicial and fair investigation.

To shed some further, but admittedly limited, perspective on Dr Hay's assertion that my husband's alpha feto proteins 'have been negative', as at 16th August 1994, it is a fact that an alpha feto protein test was earlier requested by Prof. Shields' team on my husband in March 1993 (some nine months after Prof Shields was blocked by Dr Hay in the conduction of a full liver work-up) as his medical notes show. Unfortunately, despite such a request having been made by Prof Shields' team, no such documentary evidence has ever been within my husband's files to show not only the results but actually whether the test even took place. Obviously, if my husband's records did contain a positive reading of alpha feto protein levels from that 1993 test, it would demonstrate that Dr Hay had actually overlooked this clinical data on two occasions. Nevertheless, the existence of a single overlooked reading, on July 15th 1994, of 9280, and a later assertion by the team at Newcastle that those levels were >100.000 micrograms per litre, circa 16th August 1994, would perhaps be enough for a specialist to put some time length on the likely development of cancer within my husband.

Even if this were not possible, it still remains a fact that Dr Hay was, at best, being evasive to inform Prof. GRO-D that my husband's alpha feto protein levels 'have been negative'. They hadn't been for *at least* five weeks up the date of that letter, a fact of which Dr Hay would have been well aware had his care of my husband reached even the minimally accepted standard.

It is also a point of interest to note that Dr Hay, in his letter to Prof. GRO-D is willing to place some timescale on all my husband's other complexities; such as: in references to cirrhosis, varices and aescites, he is confident and detailed enough to record, fairly accurately, the varying timescales of 'some time...the last 18 months...over the last year.'

The only matter that Dr Hay rather leaves dangling in time-scale ambiguity is when he refers to alpha feto proteins. How long, for instance, had they been negative until? Unfortunately, the only real value of Dr Hay's assertion is to say that, at some indeterminate point in my husband's medical history, his alpha feto protein levels 'have been negative', which I am sure is the case for the majority of people.

I wonder what Prof. GRO-D would have made of the matter, were he to have learned that, in actual fact, my husband's alpha feto protein levels, at the time of his writing, were >100.000 micrograms per litre, having been 9280 five weeks earlier and that only six days earlier, Dr Hay was still under the impression that my husband could be considered for a transplant?

It is clear to me that Dr Hay is trying to influence Prof. GRO-D that my husband's alpha feto protein levels had been negative up to the point of his travel to Newcastle and it was, tragically, while he was at the Freeman Hospital that the cancer first manifested itself. I also submit that this was the gist of what Dr Hay told me in the corridors of RLUH after my husband had returned from Newcastle.

Dr Hay also refers to my husband's deteriorating quality of life. He was right to do so. However, the appalling reality of my husband's deteriorating quality of life which eventually reduced him to tears - spontaneous, profuse and socially embarrassing oral bleeds, persistent styes, a hernia, leg ulcers, physically incapacitating aescites which eventually prevented him from even getting dressed, deep fatigue, insufferable and persistent itchy skin flakiness that wouldn't yield to creams, the list could go on - was such that it had been allowed to decline to almost nil long, long before a transplant was recognised, but even then not by Dr Hay, as being a possibility for my husband. In fact, almost from the time of his first varices episode, in April 1992, my husband was largely housebound, such was the unpredictability of his condition.

Given this perspective, it is has to be asked why, if he believed 'quality of life' eventually to be a factor to bear in mind when considering transplantation, Dr Hay, seemingly arbitrarily, actively blocked hepatological involvement in my husband's case during 1992 when, as notes show, he refuted Prof. Shields' submission that liver work-ups were necessary?

I submit that the value of these tests, conducted just six months after my husband was diagnosed with Hepatitis C and cirrhosis of the liver, and a full two years before he was eventually, far too late, considered for a transplant, may have hastened the decision not only to refer my husband to the joint care of a hepatologist but also to consider him for transplantation. When these major decisions were finally made some two years later, it is clear that my husband was by then facing imminent death, as occurred less than three months later.

I therefore find it utterly repugnant that Dr Hay can write that he believes the hepatologists were 'dragging their feet a bit' concerning my husband's transference to Newcastle for pre-transplant tests 1994. It is clear here that Dr Hay is attempting to lay blame (rather similar to Ms Longstaff's earlier submission that my husband was under the care of a number of specialists at more than one hospital). Therefore, he clearly believes that blame does exist. He was correct. However it is my submission to you that an overwhelmingly large portion of that blame can only be attributed to Dr Hay and that, as such, he was clearly negligent in his management of my husband.

Dr Hay also seeks to lay further blame when, after making it clear that he was on holiday at the time of my husband's encephalopathy episode, he informs Prof. GRO-D that it was only after this event that 'they...finally' sent my husband to Newcastle. Dr Hay is presumably referring here to the hepatological team at the RLUH. Again, it is clear here that Dr Hay believes that somewhere along the line, to someone, blame must be attributable for lessening my husband's chances.

You will note that Dr Hay concludes his letter to Prof. GRO-D by again demonstrating his study of haematological matters as they overlapped with hepatological issues in the wake of treatment of haemophiliacs with infected blood products, as he was confident enough to assert that he 'feels sure' that 'more cases' like my husband's will be witnessed. Again, just like he had been nine years earlier through his article in The Lancet, and no doubt in his address to the IHS in 1989, Dr Hay is remarkably prescient.

I include here Prof. GRO-D response to Dr Hay, some four months later, and three months after my husband had died (and it is clear that Prof. GRO-D did not know Dr Hay had since left RLUH) if only to demonstrate how precious time was. I also include the RLUH's response, in the new year of 1995, to Prof. GRO-D just to complete the correspondence.

(19th December 1994)

Dear Charlie,

Re: GRO-A , DOB unknown.

You may recall that a few months ago you wrote to me about the above named patient of yours with the hepatocellular carcinoma.

I am now trying to pull together as much information as possible about this particular problem and I would be grateful, therefore, if you could find time to let me have some further details of your patient.

These are:

1) Type of bleeding disorder and severity; 2) Method of HCC (sic) diagnosis and age at diagnosis; 3) Year of HCC (sic) diagnosis; 4) Date (if known) of first exposure to clotting factor concentrate; 5) HCV antibody status; 6) Hepatitis B status; 7) HIV status; 8) Alcohol intake (if known); 9) Presence or absence (if known) of cirrhosis; 10) Alpha feto protein levels; 11) It would also be useful to know whether the patient is still alive or whether he has died.

I appreciate that this might be a bit of hassle, but I am sure you will agree with me that we ought to do it.

I look forward to hearing from you,

Kindest regards,

GRO-D

(6th January 1995) From RLUH to Professor GRO-D *at the Royal Hallamshire Hospital.*

Dear Prof. GRO-D

Re: GRO-A

Here is the information you requested on GRO-A

He has (sic) severe haemophilia A. HCC was diagnosed in 1994 GRO-A *He is (sic) anti-HCV positive, Hepatitis B surface antigen negative (anti Hepatitis B surface 268), HIV negative, alcohol intake unknown, cirrhosis present, alpha feto protein levels in August 1994 was 10,000 (sic).*

GRO-A *died on the* GRO-A *1994. It is assumed he bled into his hepatoma or had a retroperineal bleed as he was shocked when admitted, however a post-mortem was not carried out.*

Yours sincerely,

Angela McKernan
Locum Consultant Haematologist

At this point in my submission, I think it also appropriate to include a verbatim transcript of the letter that was sent from Prof. Bassendine at Newcastle to Dr Gilmore on 19th August 1994, the very same day that Dr Hay was writing to Prof. GRO-D

(19th August 1994)

Dear Mr Gilmore,

Diagnosis - 1) Haemophilia A; 2) Cirrhosis secondary to chronic hepatitis C with portal hypertension; 3) Hepato cellular carcinoma

Thank you very much for asking us to assess this charming 59 year old man for liver transplantation. As discussed on the phone, we were all optimistic that he would be an ideal candidate, as transplant would not only cure his liver disease, but also his haemophilia.

As part of his work up he had an NMR scan (copy enclosed) which confirmed a small shrunken liver with splenomegaly and aescites, but unfortunately also revealed a lesion of approx. 7 cms in the left lobe possibly penetrating the capsule. On review of his Liverpool medical records we unearthed an alpha feto protein from blood taken on 15 July of 9280, confirming that he has developed a hepato cellular carcinoma, on the background of his Hepatitis C cirrhosis.

GRO-A *and his wife have been told that he has developed a growth within his liver and that this alters our decision to recommend transplantation and probably other surgery.*

They know that on his return to Liverpool, treatment options will be discussed with you, and the ones that I have mentioned are of chemotherapy and/or intrahepatic injection of alcohol directly into the growth.

GRO-A and his wife asked whether a transplant would be reconsidered if the tumour shrank and I indicated that we would happily re-discuss this with you but emphasised that he should not hold out too much hope for this, as in the past, I had had patients turned down at the assessment meeting despite some improvement in the growth.

However, it may be that we will shortly adopt a protocol using intravenous adriamycin pre-operatively during the anti-hepatic phase and post-operatively, as good results have been obtained in tumours of this size using this regime in the United States.

Certainly if his alpha feto protein falls, reflecting response to medical therapy, I would be very keen to re-discuss this option with you.

MF Bassendine
Prof. of Hepatology / Consultant Physician

A point to note is how quickly Prof. Bassendine stresses that a liver transplant for my husband would not only have cured his liver disease but also his haemophilia. Given that Dr Hay should have visibly been able to see - one would assume - the sheer deterioration of my husband before him, it again has to be asked as to why my husband wasn't considered for a transplant much, much earlier? Why did Dr Hay block the involvement of hepatologists in 1993, as evidenced in my husband's notes, when it was recommended by Prof. Shields?

The lesion that Prof. Bassendine refers to in my husband's liver was some 7cms in diameter. In mid-July it had been 6.5cms. I find it impossible to understand how Dr Hay or Dr Gilmore could have failed to note this before sending my husband to Newcastle. Either it was seen and it was ignored, in which case this was clearly negligent, or neither Dr Hay or Dr Gilmore had the expertise to be able to notice such and were therefore incapable of managing my husband, with the ensuing fact that they continued to do so itself being clearly negligent.

As you will have noted, Prof. Bassendine refers to the unearthing of an alpha feto protein reading of 9280 in my husband's notes from July 15th 1994.

Reading the transcript of Prof. Bassendine's letter, it should be clear to you how distressing the whole scenario surrounding Newcastle was for my husband and I. To have needlessly had our hopes raised to such an undreamt of extent, only then to have them not just dashed but effectively coupled with an almost certain prognosis of imminent death, is a trauma that is etched forever in my mind. They are still singularly the most distressing few days of my life and it further bolsters my submission to you that my memory of those events simply isn't capable of fading, despite Ms Longstaff's assertions to the contrary.

Quite obviously, my husband was in no fit state to even travel to Newcastle let alone undergo the physical pre-transplant work-ups and the psychological trials he endured; he should have been in his fifth week, at the very least, of chemotherapy back at RLUH, had the fact that he was even suffering from cancer been correctly interpreted.

To have allowed him to go when there was such overwhelming evidence to demonstrate that, at a stroke, it would be a wasted journey was gross negligence. If this aspect alone is not exceptional enough to justify the furthering of my husband's case, then I have to query as to what is considered exceptional or, more worryingly, the norm?

Therefore, I find it indigestible to read another absolute assertion of Ms Longstaff, when she states that no such argument exists in the case of my husband to fulfil either of the requirements of being in the public interest or being exceptional enough.

Surely an expert in his field, so evidently not applying his knowledge and his expertise to the benefit of his patients, for whatever reason, merits an investigation, on the grounds of public interest in order to ascertain as to why this was allowed to happen? Either Dr Hay deserved his reputation or he didn't? Surely the public interest is served if only to establish that there weren't other cases handled like my husband's? Surely all the evidence surrounding my husband's case bears all the hallmarks associated with being exceptional?

Rather than Ms Longstaff dismissively asserting that 'no such argument' exists to support referral of my husband's case, on the grounds of it not being either in the public interest or exceptional enough, it is my submission that the matter is evidently riddled with justifiable arguments as to why if fulfils all the onward referral requirements.

I therefore reject, unequivocally, Ms Longstaff's submission and submit that my husband's case can clearly proceed.

Ms Longstaff then goes onto state, somewhat superfluously, that this case concerns 'the management and treatment of one patient only'. I cannot see what point she is trying to make here. Naturally my case refers to only one person, my husband. But surely one of the matters to establish from investigating my husband's case is that it wasn't part of a wider standard concerning other patients? Again, if Dr Hay's management of my husband was indicative of his wider standards, then surely negligence applies. Conversely, if it was just an isolated case of negligent management - and my submission to you is that negligence is beyond dispute - then it has to be asked, again, as to how my husband was so unfortunate, at best, to be treated such over a sustained period?

Ms Longstaff also seeks to reduce my husband's clearly sizeable case to just three bullet points. Whilst I can appreciate her attempts at shorthand, at least for ease of reference, I regard this as a rather belittling diversionary tactic, presumably hoping to gloss over many crucial elements of my husband's treatment. My husband's case simply cannot be boiled down in such a manner - if only it were so - whilst also reflecting the sheer gravity of the consequential episodes. Either Ms Longstaff seeks to veil certain aspects of my husband's suffering or she is displaying her lack of knowledge surrounding the case. Either way, Ms Longstaff's admirable shorthand references are not an adequate reflection of reality, especially in a case of such magnitude.

There were scores of key milestone events that unfolded between the bullet point junctures that Ms Longstaff uses to boil down my husband's suffering. In many instances, these episodes were far bigger and far graver than the neutralised headlines that Ms Longstaff has employed.

For instance, between bullets 2 and 3 - i.e. *Management of his liver cirrhosis from January 1992* to *Management of a hepatocellular carcinoma diagnosed in 1994* - there could be several quite stark headlines that could be inserted to give a truer picture as to the gravity of this case. For example *'Continuing failure to refer patient to a liver specialist'* to *'Deliberate veto of liver specialist involvement even when it was suggested'* to *'Failure to correctly identify patient was suffering from cancer'*. The list could go on, but I submit to you that Ms Longstaff's breezy and rather disingenuous reference to some, or what she presumably believes to be the key, events in my husband's case, is insubstantial and can be disregarded as an adequate overview of the pertinent facts and episodes.

Ms Longstaff's emphasis that my husband's matters are 'private' is also another deflection-attempting irrelevance. Of course his matters are private but, as his surviving spouse, it is clear that I am again surrendering my long-abandoned preference to keep such matters private. If only I still had that refuge. As I have stated, my husband's private suffering has been publicly aired across several media channels for many years now, particularly in relation to the ongoing and quite arduous campaign to have the British government address the bereaved families of deceased HCV haemophiliacs. Whilst I do appreciate the apparent concerns that Ms Longstaff seems to have for the sensitivities surrounding my husband's suffering, I can assure you that, out of necessity, I have long-since had to abandon this privilege and quite obviously I am doing so again.

Furthermore, as to Ms Longstaff's assertion that the matters surrounding my husband's case are 'unique', then, I would have to say, it must be hoped that they are. In any case, whether they were unique or not is an irrelevance. If they were unique, then it has to be determined as to why my husband was allowed to suffer so; if they were not unique, then obviously the gravity of that matter also demands exploration.

Further, whilst I am at least assured that Ms Longstaff appreciates that the circumstances of my husband's death 'were no doubt sad' - and she is right - they were self-evidently exceptional, at least it is hoped that they were and not reflective of the norm.

I therefore reject all of Ms Longstaff's submissions recommending no further referral of my husband's case on the grounds of it neither being in the public interest, nor exceptional enough, or relating only to one patient, or being too private, or unique. My husband's case can clearly proceed.

8. Ms Longstaff states:

Finally, the screener should take into account the facts that:

> •*As far as Dr Hay is aware, the Complainant did not pursue a complaint through the hospital complaints procedure at the time,*
> • *The Complainant has already attempted legal action in respect of these events, which failed in the late 1990's.*

Ms Longstaff is correct in her tentative assertion that 'as far as Dr Hay is aware,' I did not pursue a complaint through the hospital complaints procedure at the time. I did not do so for several reasons.

Firstly, in the immediate aftermath of my husband's death, I not only had to contend with the considerable grieving process ahead of me, but the issue of financial redress for the bereaved families of Hepatitis C-infected haemophiliacs, as consistent with the reparation made to the bereaved families of HIV-infected haemophiliacs, including, of course, the families of my husband's other two haemophiliac brothers. This matter was suddenly propelled into the national media spotlight within weeks of my husband's death and, as his case was infamously part of the previously referred to scenario of the 'three brothers', it immediately became something of a test-case and consequently much of my time was swallowed in preparing relevant submissions in relation to this. I am sure that you and Ms Longstaff can appreciate how arduous and traumatic this was for me at the time, swallowing much of the first year after my husband died when clearly I should have been allowed to grieve without resorting to such campaigns.

Furthermore, it was not until Christmas 1996 that, after many requests, I was finally able to access my husband's medical records, the reading of which was, given how voluminous they were, as painstaking as it was traumatic.

It was only after reading these notes, over two years after his death, that I was finally able to confirm my increasing suspicions that my husband had in fact been negligently managed. The decision I then faced was which way to best pursue a case of medical negligence. Considering that I was already involved in the formation of a case against the British government - which still exists to this day - I had to make a pragmatic decision as to how best to pursue a parallel submission of medical negligence regarding the specifics of the management of my husband at the RLUH.

Several events over the course of a period, stretching from immediately after my husband returned from Newcastle to 11 weeks after his death, influenced my eventual decision not to pursue a complaint through the hospital complaints procedure, if in fact it wasn't already too late for me to be able to do so by the early part of 1997.

Firstly, there were two conversations I had with Dr Hay in that period. I have earlier related the first of those occasions, which took place in the corridors of the RLUH immediately following my husband's return from Newcastle after being diagnosed with liver cancer. Dr Hay arrogantly and, without solicitation, tersely informed me that 'he never had cancer when he left here.' You will recall from earlier in this submission that Dr Hay was also at that time writing to Prof. GRO-D to this effect by stating that my husband's alpha feto protein levels "have been negative".

A second conversation with Dr Hay then took place in the corridors of a hotel in Coventry in November 1994, 11 weeks after my husband's death, where he, like I, was an attendee at the UK Haemophilia Society's AGM. Again without solicitation - in fact I did not want to speak to him - Dr Hay, in an unduly dismissive way, especially considering I had only been a widow for such a short period, informed me that 'I did all I could' for my husband. I had no choice but to accept this and although my suspicions about negligence were only just beginning to crystallise, I was immediately sceptical about Dr Hay's continuing and unsolicited stance, especially in light of the earlier conversation he had with me at the RLUH.

However, I recalled Dr Hay's words, on both of those occasions, when I read my husband's medical notes some two years later and realised the depth of the negligence he experienced and that it most certainly was not the case that my husband didn't have cancer when he left Liverpool for Newcastle. It was also clear that Dr Hay had not done all that he could for my husband.

Another matter influencing my decision not to pursue matters through the hospital complaints procedure was my rather naive acceptance, in October 1994, of Dr Ian Gilmore's verbal assertions to me, and my two children, that nothing more could have been done for my husband considering how 'late in the day' he had been referred to the hepatologist unit at the RLUH.

Dr Gilmore spoke to me and my two children in his office at the RLUH during a meeting that he himself had prompted, for which I was grateful for at the time. Still in a deep sense of grief at that point, I did not realise the significance of what Dr Gilmore said to me regarding the tardiness of my husband's referral to the hepatologists at RLUH (this was similar to my naive acceptance, during the course of my husband's decline, when I never queried Dr Hay's inactivity in not referring my husband on - instead having complete, but eventually wavering, faith in an expert who I believed to have my husband's best interests at heart).

Instead, I paid more attention to Dr Gilmore's assertion that, as he put it, under the circumstances, everything that could have been done for my husband was done. At this point, it must be remembered, I had absolutely no idea that my husband had cancer before he went to Newcastle. Instead, influenced by Dr Hay, I believed, right up to my husband's death, and beyond, that he had just been so extremely unlucky to have developed cancer in the few days whilst he was actually at Newcastle. My husband and I were actually under the impression that we were lucky that Newcastle had detected it so early. Ironically, this even gave my husband false hope that his chances with chemoptherapy would be at the maximum because cancer had only just surfaced. Therefore, given my understanding of matters at the time I spoke to Dr Gilmore, in October 1994, I had no reason to think more deeply about his words and accepted his assurance, which although untrue, was delivered rather more gently than Dr Hay's abrasive assertions that everything that could have been done for my husband was done.

You can imagine my utter shock when eventually I read my husband's medical notes, to realise that not only had my increasing suspicions about his treatment been borne out, but that they had been magnified massively. I could only recall the words of both Drs Hay and Gilmore with utter contempt as it was clearly untrue that everything that could have been done for my husband was done.

Consequently, I judged that any chances of success I would have in pursuing a case of medical negligence against the RLUH and/or Dr Hay and/or Dr Gilmore would be best served in a route other than the hospital complaints procedure, as I had no faith that the investigation would be objective, especially given the already demonstrated stances of both Drs Hay and Gilmore.

While Ms Longstaff is correct in her assertion that I have already attempted legal action in respect of this case, she is quite incorrect to say that it 'failed'. She is correct though to refer to this action as having been 'in the late 1990s' which underlines how long it took for me to be able to formulate that case.

You will have known, in my earlier submissions to you, that I have not hidden the fact that I have already tried to pursue this matter through legal avenues - I have not hidden this. As I have stated earlier, my immediate priority - the timescale of which was rather forced on me, as my husband was deemed to be part of that 'test case' involving his three brothers - was to formulate a case against the British government for compensation for bereaved families of Hepatitis C haemophiliacs, as consistent with that of bereaved families of HIV haemophiliacs.

Naturally, this necessitated the seeking of legal advice and the requested access to my husband's medical records. Before I could even progress down this road though, I had to pursue a claim for legal financial aid as I had not the funds to progress such a matter on my own. The approval of my legal finances itself swallowed up much of the immediate period after my husband's death. Only after I was able to establish that I could support such a case did I learn that I would have to initially bring a case against the health authority in the first instance before then being able to bring matters against the British government.

For this course of action to proceed, of course, I had to gain access to my husband's medical records. Although these records were, in the first instance, accessed to support a case against the health authority and the British government, it was also my intention to scrutinise these materials to establish the true facts surrounding the specific management of my husband, primarily by Dr Hay, with a view to seeing if they supported the now considerable suspicions that I then had that he was negligently treated.

Naturally, though, I could not progress on any front until those records were obtained. An anxiety of mine though was that I knew in order to progress any case of medical negligence that I would have to initiate proceedings within three years of my husband's death - i.e. by GRO-A 1997. Despite repeated requests from my counsel, the procedure of this case was stifled through inexplicably long delays by the RLUH in their release of my husband's medical notes. In the end, I only achieved access to those files at Christmas 1996, over two years after my husband's death.

You will immediately appreciate that this left only nine months, and in reality much less than that, in order for this case to proceed. Alongside this, I was still having to formulate a case against the British government.

As my records, if you require access to them, will show, the period between Christmas 1996 and GRO-A 1997 was also beset by further delays, particularly regarding the identification of independent experts who were both competent enough and willing enough to pass judgement in the case of medical negligence experienced by my husband.

Identification of such experts took many months and the situation was not at all helped by the fact that, after initially promising his assistance, one of the experts suddenly informed us, with only a few months remaining before deadline, that he would no longer be able to help. He gave no reason for this unexpected withdrawal. Naturally this impacted the timely development of the case to some significant degree.

Another significant setback was that, even after the panel of experts had been finalised, the length of time before their submissions were actually received saturated much of the remaining time; although to an extent this was inevitable considering how voluminous my husband's medical records were.

In eventuality, it prevented my counsel from formulating its case until during the Bank Holiday period of August 1997 - as my records, if you require them, will show - and it inevitably meant that we would not be able to initiate proceedings within the strict timetable.

Furthermore, the legal financial assistance I had benefited from, for some two and a half years at that point, reached a finite point in terms of costs already incurred.

On two fronts therefore, I was prevented from furthering my proceedings regarding medical negligence against the RLUH and/or Dr Hay and/or Dr Gilmore.

I am sure you will appreciate the frustration I felt at that time when, after three years of trying I was simply unable to press proceedings any further. As Ms Longstaff has correctly asserted, therefore, the matter did indeed reach the late 1990s, however she is quite wrong to say that legal action 'failed'. It did not fail because it was never given the chance to either fail or succeed. I do find Ms Longstaff's statement, that it 'failed', somewhat curious given that she later goes on to point out that proceedings never materialised. If she knows that proceedings never materialised it is hard to see how she can conclude that they 'failed'.

It did not fail because it was never allowed to. However, it my submission to you that, had I have had the opportunity to progress matters further, then my action would, in fact, have succeeded.

It is also difficult to reconcile Ms Longstaff's earlier submission that Dr Hay only has 'some recollection' of my husband with the fact that he seems to be able to recall specifics such as me not pressing a case through the hospital complaints procedure and that I also attempted legal action in the late 1990s. Either he can substantively recall my husband's case - and it my submission to you that he most certainly can - or he can't.

Nevertheless, I trust I have clarified the reasons as to why I didn't progress matters through the hospital complaints procedure and also why formal legal proceedings - which most emphatically did not fail - were prevented from progressing.

9. Ms Longstaff states:

The statement which GRO-A has provided in support of her complaint to the Council was originally made in 1997 in support of a claim for damages for medical negligence. Dr Hay understands that GRO-A GRO-A had the benefit of legal advice and assistance in investigating that claim and that an independent expert report was obtained on her behalf. That expert report was never disclosed but it must be presumed that it was unsupportive of the Complainant's case because shortly afterwards the claim was discontinued. In fact formal civil proceedings were never issued.

Ms Longstaff is correct to state that one of the statements I have provided to you in support of my claim against Dr Hay was originally made in 1997 during the preparation of the legal action referred to above. In fact, I made it clear to you that such was the case in my earlier submission. However, I also, in my earlier submission to the Council, made a newer submission to you entitled 'The Case Against Dr CRM Hay' - as I was requested to. I note that Ms Longstaff has chosen to overlook this statement in her response to you and chooses only to cite the existence of the previous, seven year old statement. In any case, I would submit to you that both statements are in fact complementary and whether one of them is seven years old is an irrelevance.

Further, given Ms Longstaff's repeated references to the passage of time and her anxiety that it could render memories unreliable, I would submit that the statement I made in 1997 - less than three years after my husband's death - should at least be regarded by her as a reliable statement.

Although Dr Hay only has 'some recollection' of my husband, he is right to understand - however he has reached his belief - that I did indeed have the benefit of legal advice in 1997 and that an independent report was produced on my behalf. I trust, though, that I have already clarified the matters surrounding this actuality, and stress further that I have made no attempt to hide such facts from you, simply because I have no need to.

Ms Longstaff then enters the realm of conjecture again by 'presuming' - even though it was never disclosed - that the independent expert report was 'unsupportive' of my case, chiefly because my claim was shortly afterwards discontinued.

I have made it clear as to why these matters were reluctantly discontinued and would caution Ms Longstaff against her presumptions. As I have indicated, I would have welcomed the ability to progress my case further in the wake of receiving that independent report but unfortunately I was only prevented from doing so by chronological and financial factors.

So while Ms Longstaff is correct to say that formal proceedings were never issued - which Dr Hay would surely be aware of - I submit to you that it is nevertheless dangerous for her to presume that I did not do because the independent report did not support my claim.

10. Ms Longstaff states:

It is noted that the Complainant has chosen not to share a copy of that independent expert report with the Council, presumably because it does not support her position.

It is quite wrong of Ms Longstaff to state that I have not 'chosen' to share a copy of that independent report with you. You will know that in previous submissions I have drawn your attention to my previous legal activities regarding this matter. Had you have requested a copy of any materials supplementary to that activity, such as the independent report, I would gladly have shared them with you - as is still the case. Nevertheless, I judged that these documents could in fact prejudice your investigations, insofar as I assumed you would wish to maintain objectivity in order to reach your conclusions, free of the earlier judgements of others.

I therefore interpreted, rightly or wrongly, the fact that you did not request any materials relating to my previous legal activities between 1994 and 1997 as an indication that you did indeed wish to proceed unprejudiced by the conclusions of earlier enquiries. While I would certainly support this as the most appropriate approach, I equally would not wish to presume any aspect of the Council's correspondence with me so far and I would readily concede, if appropriate, that I may unwittingly have misinterpreted any non-requests of materials. To that end, I am fully prepared, if you so wish, to let you see copies of the independent expert reports - to which Ms Longstaff alludes - that I possess.

It is, though, incorrect, of Ms Longstaff to say that I have 'chosen' not to share these materials with you and it is misguided of her to presume their contents.

11. Ms Longstaff states:

Thus it appears that the Complainant has already had the opportunity fully to explore the issues in this case, and she has the benefit of an independent expert report (which she has not disclosed). GRO-A GRO-A *is now trying to open the same allegations and explore the same issues, through the General Medical Council. It is submitted that this is inappropriate and an unreasonable waste of the Council's time.*

While it may appear to Ms Longstaff that I have already had the opportunity 'fully to explore the issues in this case' it is in fact incorrect of her to say so.

The fact that I was frustratingly prevented from progressing my previous legal activities, through no fault of my own - especially after obtaining independent expert reports - itself underlines that I did not 'fully' have the chance to explore this matter.

It is my submission to you that I still wish I were able to have progressed matters further in order to have 'fully' explored the issues but I was unfortunately prevented from doing so. Therefore, I completely reject Ms Longstaff's assertions on this point.

Ms Longstaff is right to say that I am 'trying to open the same allegations and issues,' through the Council. Of course I am. Moreover, the allegations and issues can only remain the same, regardless of the passage of time. It has been a lasting frustration of mine that I was never able to fully explore the matters of this case and I felt that I reluctantly had no choice but to accept this reality.

However, I was encouraged when I first learned, some 10 months ago, about the possibility of re-attempting an exploration of these issues through the channel of the General Medical Council. Had I have known about this channel, I would have sought recourse to it a long time ago. Sadly I did not and I can only submit to you that the reason I am now doing so after so long a time is that I simply wasn't aware of it as a viable option.

I can assure you that I would have liked to have explore these issues through the General Medical Council many years ago and so avoid the pain of still having to revisit my husband's case so many years later, especially with the added poignancy that we are now upon the 10th anniversary of learning that he was a 'suitable' candidate for a liver transplant.

I reject Ms Longstaff's dismissiveness that my submission is now 'inappropriate' and especially her rather arrogant assertion that it is 'an unreasonable waste' of time. I also detect, rightly or wrongly, a note of inferred tedium from Ms Longstaff behind this statement. Whilst I submit to you that, given the circumstances - however long it is since they occurred, it is most certainly not 'inappropriate' to further this matter and certainly not 'an unreasonable' waste of your time, and that it is much more than a case of mere tedium for me. It is deeply traumatic and time-consuming for me to have to do this and I would trust that the fact I am having to do so - especially at so poignant a time - is self-evidence of the depth of injustice I feel.

Rather than it being an unreasonable waste of the Council's time, it is my submission to you that I trust it does not become an unreasonable waste of my time, coupled with further injury, especially after going to the lengths I already have, particularly the preparation of this response which has been traumatic in itself.

12. Ms Longstaff states:

Dr Hay would like to make it clear that he firmly refutes all the allegations and criticisms made by the Complainant, and reserves all his rights to provide comments on the substantive issues if this proves necessary. As a preliminary issue however it is submitted that the screener should have regard to the five year rule and properly conclude that no further action can be taken, and this enquiry should be brought to an end.

I have said earlier that I am not surprised to learn that Dr Hay refutes all of the allegations against him. However I am surprised that he is so trenchant in his position based not only on the evidence I have shared with you, but also based on the fact that he has only read 'a few' of the documents that he has been able to access.

I would submit that before Dr Hay fully refuted all the allegations against him, he should have consulted a complete file of my husband's records. This is especially so considering that he also only has 'some recollection' of my husband. I therefore cannot see how Dr Hay arrived at his position. Furthermore, in Dr Hay's situation, especially after electing to allow his counsel to respond to you at this immature stage in his investigations, I would have thought a few cautionary noises would be more appropriate pending the release of further materials.

I submit that Ms Longstaff's response is therefore ill-considered and ill-formed, especially on the basis of so little evidence, apparently, having been read. I also submit that it is my conviction that, on reading all the evidence available, Dr Hay must ultimately conclude that he at least has to modify his position, if not totally abandon it, and offer an adequate explanation, perhaps containing an apology, twinned with recognition of undue suffering, as to why he managed my husband so.

I fully respect Ms Longstaff's submission that Dr Hay reserves all his rights to provide comments on the substantive issues, which I indeed would welcome, although I reserve judgement as to what Ms Longstaff's interpretation of 'substantive' is. As I have emphasised several times earlier, I believe that there is more than enough justification for the screener to disregard the five year rule in this instance, on the very safest grounds.

Further, I would regard it as an improper conclusion if the screener were to recommend no further action, particularly in the light of the case having reached thus far. It should be starkly clear to you that the management my husband received - according to the documentary evidence available - was at best sub-standard. There are a myriad instances that can be pointed to in order to support my submission of negligence on the part of Dr Hay.

My husband suffered dreadfully and it must be established as to why he did so, particularly in so exceptional a way, no matter how long it has been since. It must also be established that others did not suffer in a similar way.

The tragedy meted out to the haemophiliac community in general - as so starkly illustrated by the events within my husband's own family - was hard enough to bear in itself in the wake of being infected with contaminated NHS blood products. But, in my husband's instance, to have such pain compounded by further inestimable injury in the shape of the treatment I have described was simply unacceptable and fully merits investigation.

My husband was an utterly helpless, extremely vulnerable man - desperate for any respite offered him - and both he and I trusted implicitly the medics appointed to care for him over several years. It is starkly clear to me that such trust was hideously misplaced and I submit to the Council that an investigation as to how and why this was the case must be conducted.

This case must progress.

I anticipate your considered response in due course,

Yours sincerely,

GRO-C

GRO-A

15th June 2004

MEDICAL PROTECTION SOCIETY

RECEIVED
12 ... 2004

Direct Line: GRO-C
Direct Claims Fax: GRO-C
Secretary: Helen Huby (9.30am ~ 5.30pm)

Mr Tim Cox-Brown
Caseworker
Fitness to Practise Directorate
5th Floor St James's Buildings
79 Oxford Street
Manchester M1 6FQ

Our Ref: CL/HH/540234
Your Ref:TCB/FPD/2004/0781

9th July 2004

BY FAX AND POST – GRO-C

Dear Mr Cox-Brown

Re: Dr. C.R.M. Hay

I refer to your letter to Dr Hay of 21st June 2004, and our subsequent telephone conversation in which you reported that:

- You were not willing to disclose copies of the correspondence referred to in the second page of the Complainant's letter of 15th June 2004, and
- A medical screener had already considered the issue of the five year rule in isolation, and determined that the enquiry should proceed.

As indicated, I was surprised and concerned to receive this information and submitted that the Council was guilty of a grave error of procedure. Any decision involving an exercise of discretion on the part of the Council should be transparent and cannot be made without the benefit of submissions on the part of both parties.

In the circumstances, you have agreed that the case will be submitted to the next available medical screener, so that it can be considered with a fresh pair of eyes. It is important however that the correct procedure is complied with. On behalf of Dr Hay I would submit that the new medical screener should not be provided with any documents which have not been seen by Dr Hay; nor should he/she be provided with any material relating to the previous (invalid) decision.

The purpose of this request, as I am sure you will appreciate, is to uphold the rules of natural justice, and to protect the Council from any allegations of abuse of process.

Thank you for sending me a copy of the Complainant's letter of 15th June 2004. This does not add greatly to the preliminary point of principle which falls to be determined but I would like to make the following points:

1. The Complainant confirms that this is a "massively complex" case, and that the events in question took place over ten years ago. In fact it is suggested that it will be necessary to refer back to before that period in order to contextualise matters. GRO-A also asserts that her own recollection of these events is entirely reliable, although clearly she is unable to speak for any other witnesses. The medical screener must appreciate that all these assertions go to support the contention that at this stage it would be extremely difficult to conduct a non-prejudicial inquiry, and to ensure fairness in the proceedings.

2. The Complainant also confirms that the medical records are voluminous and that certain notes are missing; she refers in particular to an alpha feta protein test requested in March 1993. I would point out that this report was not requested by Dr Hay, but by another specialist. If this case were referred forward it would be a great injustice to Dr Hay if he were asked to comment on the absence of medical records not actually commissioned by himself. This is another example of the way in which Dr Hay might find himself severely prejudiced if this matter were allowed to proceed.

3. The Complainant has taken issue with the suggestion that a number of different practitioners were involved in this patient's care and yet it is clear, even from the limited extracts from the records attached to the initial letter of complaint, that the patient was under the care of a number of treating consultants during the period in question. I understand that the screener may even have access to a complete set of the records (which have apparently been lodged at the Council's Manchester office by Mrs GRO-A from which it will be clear that from 1992 the patient was under regular review by Professor Sir Robert Shields, Head of the Academic Surgical Unit specialising in management of liver disease, especially cirrhosis. Dr Hay is not seeking to attribute blame whatsoever but would like to make it clear that he would have some difficulty addressing the principal allegations in this case, because they appear to relate to a time when the patient's liver disease was predominantly managed by Professor Sir Robert Shields. Ultimately it is not clear what the exact allegations are and to whom they should properly relate.

4. The Complainant has suggested that the public interest argument comes into play because Dr Hay is a renowned expert. In the first instance, I would submit that it seems manifestly unfair that a practitioner with particular expertise should not have the proper protection of the five year rule, in a case where events in question occurred over 10 years ago, where any other practitioner would. Furthermore, as previously expressed, while the circumstances of GRO-A death were no doubt sad they cannot be described as exceptional and it would be an illogical extrapolation of Rule 6(8) to suggest that the death of any patient of an eminent medical professional should automatically lead to an investigation by the General Medical Council. GRO-A argues strongly and at length that her husband was managed negligently but the medical screener must not lose sight of the fact that Dr Hay firmly refutes these allegations, and believes they are unfounded.

5. The Complainant confirms that she never made a complaint through the NHS complaints system, but that she did attempt to make a civil claim for damages in 1996/97, which was not pursued. She also confirms that she obtained independent expert reports in relation that claim, but has not produced copies of those reports, and has remained silent on the question of whether they supported her case.

6. The Complainant implies she was partly prevented from commencing legal proceedings by chronological factors, and the expiry of the three year limitation period. However this argument does not convince. By August 1997, according to the Complainant's own account, the medical records were available, independent expert reports had been obtained and legal Counsel had advised. GRO-A was certainly in a position to issue proceedings prior to the 3rd September 1997. If Counsel was unable to formulate detailed particulars of claim immediately, then it was open to GRO-A solicitors to issue protective proceedings, and it would still not have been necessary to serve the detailed case for another four months. After that GRO-A solicitors could have applied for an extension of time for service of the formal proceedings. All of these are common proceedings in civil litigation and should not prevent a Claimant with a meritorious case from pursuing their claim.

7. In the circumstances it is open to the Screener to conclude that the expert evidence was not supportive of the case and that GRO-A was advised by her lawyers not to pursue a claim, which would need to be established on the balance of probabilities (where her allegation to the GMC would need to be established to the higher, criminal standard).

8. The Screener may wonder why this particular complaint has been re-opened at this stage. By way of explanation, GRO-A has said that she only first learned about the possibility of reattempting an exploration of these issues through the channel of the General Medical Council some ten months ago. This may well be the case, but the Screener may wish to consider whether a more comprehensive answer lies in the wider issues for the haemophilia community. The Screener is probably aware that ten months ago, the Department of Health launched a compensation scheme whereby £20,000 is awarded to any patient who contracted hepatitis C from contaminated blood products, and £45,000 for the families of any patients who died after September 2003 from liver disease caused by contaminated blood products. However, the dependants of patients who died prior to September 2003 do not receive anything and therefore individuals such as GRO-A are excluded from this scheme.

For the record, Dr Hay would like to make it clear that he appreciates that some families within the haemophiliac community must feel great resentment, and he understands why campaigning groups have made representations to the Department of Health arguing for a change in the scheme. He has made similar representations himself. However it is possible, and it will be put no higher than that, that a concern about the compensation scheme is in part the precipitating cause for GRO-A present complaint. If this should be the case then the medical screener should have regard to the wider issues, and question whether further investigation of this complaint could be justified as an appropriate use of the Council's resources.

In conclusion, it is submitted that the medical screener should have regard to the five year rule which clearly states that, pursuant to the rules of Council, this allegation may not be referred to the Preliminary Proceedings Committee. For the avoidance of doubt, I would like to make it clear that any decision concerning discretion can only be made at this stage, by the medical screener, and that it is not a decision which can be passed on to the Preliminary Proceedings Committee.

If, despite these submissions, a decision is made to refer this case to the Preliminary Proceedings Committee, I specifically request that reasons for such referral are provided.

Yours sincerely

GRO-C

Catherine Longstaff
Solicitor
Claims and Legal Services Division

In reply please quote: RG/FPD/2004/0781

30 March 2005

GRO-A
Liverpool
GRO-A

GENERAL
MEDICAL
COUNCIL
Protecting patients,
guiding doctors

Dear GRO-A

I refer to our previous correspondence regarding your complaint about Dr. Hay.

In accordance with Rule 8 of the General Medical Council (Fitness to Practise) Rules 2004, the Case Examiners have considered your complaint. They have concluded that we do not need to take any further action on Dr. Hay's registration, in respect of this.

When making their decision, the Case Examiners must consider whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration. In doing so, they must have in mind the GMC's duty to act in the public interest, which includes the protection of patients and maintaining public confidence in the profession.

They first consider the seriousness of the allegations and then whether the GMC is capable of establishing that the facts demonstrate the practitioner's fitness to practise is impaired to a degree justifying action on registration.

The Case Examiners concluded in this case that, whilst the allegations were serious, there was no realistic prospect of establishing that Dr. Hay's fitness to practise is impaired to a degree justifying action on his registration.

In your complaint you alleged that Dr. Hay failed to diagnose liver disease in GRO-A GRO-A failed to test for Hepatitis C, failed to refer to a hepatologist, failed to communicate the clinical condition of "liver failure" to GRO-A failed to refer for or recommend a liver transplant, refused to refer to specialist Dr. Gilmore, failed to diagnose and treat liver cancer early enough, and prevented full liver tests being undertaken.

Specifically, with respect to the allegation that Dr. Hay failed to diagnose liver disease in GRO-A you instigated a civil action for damages and we have copies of the opinions on file. They do not support your allegations and accordingly your solicitors dropped the action. Cirrhosis of the liver was diagnosed in 1992 following knee surgery. There is nothing to indicate that this surgery was contraindicated or had any adverse effect on GRO-A liver disease. Your expert hepatologist confirms that this is the case and that earlier diagnosis via biopsy would have been very unusual practice at the time.

5th Floor St James's Buildings 79 Oxford Street Manchester M1 6FQ Telephone 0845 357 8001 Fax 0845 35
email gmc@gmc-uk.org www.gmc-uk.org

Regarding the allegation that Dr. Hay failed to test for Hepatitis C, the Hepatitis C test only became available in late 1991 and Dr. Hay began testing in early 1992. This is therefore not an issue to justify action on Dr. Hay's registration.

As to the allegation that Dr. Hay failed to refer to a hepatologist, Dr. Hay was an experienced consultant and it was reasonable for him to manage GRO-A care himself. The independent expert view was the liver disease was appropriately managed with very effective treatment of the patient's oesophageal varices. No action on Dr. Hay's registration is therefore indicated.

Pertaining to the allegation that Dr. Hay failed to communicate the clinical condition of "liver failure" to GRO-A, GRO-A liver function was regularly monitored and discussions about the diagnosis documented. There is no evidence that any information was deliberately withheld and therefore no action on Dr. Hay's registration is indicated.

Regarding the allegation that Dr. Hay failed to refer for or recommend a liver transplant, at the time it is clear that liver transplantation was a last resort measure, particularly with the increased morbidity and mortality associated with patients who had haemophilia. When his liver functioned deteriorated, GRO-A was referred. Unfortunately, this deterioration coincided with the diagnosis of a malignant liver tumour so removing transplantation as an option.

With respect to the allegation that Dr. Hay failed to refer GRO-A to Dr. Gilmore, GRO-A was referred. Unfortunately it was at a stage when the hepatoma was diagnosed. There is no evidence that Dr. Hay or any other doctor failed to act on evidence that would have led to an earlier diagnosis.

As regards the allegation that Dr. Hay failed to diagnose and treat liver cancer early enough, the blood test result indicating a possible hepatoma was first recorded in excess of 9000 in July. By August it was greater than 1000000. This is a large rise in a short space of time and occurred in combination with GRO-A worsening clinical condition. It was not routine accepted practice to "screen" patients with cirrhosis for liver cancer and Dr. Hay's management is what might reasonably have been expected.

The last allegation was that Dr. Hay prevented full liver tests being undertaken. A full liver work up may have involved risk-laden procedures such as liver biopsy, the complications from which are multiplied in patients with a bleeding disorder such as haemophilia. Professor Shields discussed the pros and cons with the haemophilia specialist – Dr. Hay, who can be said to have been acting in his patient's best interest.

I acknowledge that this may be disappointing news for you but hope that given our explanation you understand the reasons for our decision.

Yours sincerely,

GRO-C

GRO-D
Investigation Officer
Fitness to Practise Directorate
Direct Dial: GRO-C
Fax No: GRO-C
Email: GRO-D GRO-C

Our response to the PDF submission of an evidence file, sent to us – Maureen Murphy, Anne Anakin and Gregory Murphy – by Leigh Day solicitors on August 13th, 2020; referring to "*a complaint by Maureen Murphy (on behalf of Mr William Murphy) against Dr Ian Thomas Gilmore (1504220) & Dr Charles Hay (2310390), GMC Reference: 2004/0781*" in 2004.

-

1. Preamble:

Unfortunately, an initially negative tone.

It was disheartening that the Infected Blood Inquiry (IBI) granted us just six days to provide our response, especially at such a signal moment in our long justice campaign. We realise that we are probably already too late by some 24 hours in providing our response. Nevertheless, we still submit it and trust that somebody may read it at some point. We think there may be some value within. Also, due to the time constraints imposed upon us, we haven't had the time we would have wished to properly proof-read our responses; so we raise in advance that there may be unfortunate literal errors in our submission.

-

The type of short-notice feature referred to above – giving us hardly any chronological scope to reply – has actually been a repeated pattern over the last 26 years since William's death as we have fought for justice; especially on two very notable other occasions, in 1997 and 2007, about which we will here provide some broader context to explain, we trust, our current disappointment.

Firstly, after three years of striving – between September 4th, 1994 and September 2nd, 1997 – and competing against what we believed (until our receipt of documents last week, ironically) was a strict three-year legal timetable in which to lodge our first, unfulfilled allegation of medical negligence (initially against any or all of: the UK Government; the Royal Liverpool University and Broadgreen Hospitals; the Mersey Region Health Authority; Dr Charles Hay; and Dr Ian Gilmore), we finally only acquired counsel's opinion with just 72 hours remaining of a 36-month deadline. That is a provable, documented fact. We were therefore required to make a monumental decision, with so many other variable factors to consider (not least financial), effectively overnight.

The consequences of the pragmatic decision we felt that we had no choice but to make in the very final hours of August 1997 have haunted us since. Indeed, the ramifications were even writ large in the significant PDF evidence file sent to us only last week. It was hugely frustrating for us, 23 years ago, to know that all of our efforts between autumn 1994 and autumn 1997 – which actually haven't yet been reflected in evidence so far submitted to the IBI – were eventually stymied by such an unfair, 11th hour timetable forced upon us.

Secondly, just short of a decade later, in April 2007, we were subject to an even tighter timetable which ultimately undermined our evidence in the very first minutes of the Archer Inquiry, the negative effects of which have also had ramifications over the last 13 years plus (not least that we failed to feature in the final Inquiry report).

For after many months of meticulous planning with legal representatives, even with a last minute review conducted via telephone conversations as late as 10.00pm on the evening prior to the Inquiry's commencement, all of our preparations were effectively torn-up at the very last minute (and we do not exaggerate). We were given less than half-an-hour's warning the following morning that everything had changed.

Essentially, we were expected to abandon all preparations that we had put our heart and soul into for months and learn a completely new (and deeply unsatisfactory) method of presenting evidence – and do so live on national TV, no less – in the final 30 minutes prior to the start of the Inquiry. We never received any explanation as to why, nor indeed as to who made the decision to completely undermine us. Further, we were later upbraided by Lord Archer for even registering dissatisfaction; essentially, we should have been grateful that the Inquiry was even being held.

There was never any human appreciation – concerning both of the above signal occasions – as to how daunting it has always been to find ourselves amidst the ongoing trauma of the Contaminated Blood Scandal (CBS), our preferred term, and endure this seemingly never-ending fight for justice. There was also never any understanding as to just how dispiriting it was to then have our dedicated efforts undermined by completely unrealistic timetables thrust upon us at the very last moment.

And now here we are, in late 2020 – almost 26 years since William's death – with history already several times repeated now being replayed. Further, you will also see in the evidence we will supply later, even in this very document, how, on yet another occasion, in spring 2004, the General Medical Council (GMC) also imposed a completely unrealistic response timetable upon us which we had no choice but to adhere to.

We should never have had to endure this type of unreasonable timetabling even once over the last 26 or so years, let alone several times. And certainly not now that we are in the era of the IBI.

It's over a year since we initially submitted the first part of our Witness Statement (WITN1944001/ WITN1944002/WITN1944003). It's been some six months since we sent our respective signatures to that combined submission (Maureen, Anne and Gregory) as validation (as sent by registered post to the IBI, in week commencing March 15th, 2020; the week before national lockdown). And whilst we haven't been unduly concerned about the silences since (especially given the unprecedented circumstances of 2020 – and we've just trusted that the Inquiry wheels have been turning in the background; and we're incredibly gratified knowing that such has been the case, please know that) we were nevertheless thoroughly despondent last week to note that we had once again been granted such a short period in which to provide responses to the lengthy submissions.

Once again, we were left with an all-too-familiar, gut-turning predicament that has peppered our 26-year fight: do we even dare complain? Shouldn't we just be grateful, instead?

To try and put things into perspective:

Try to imagine what a seminal day it was for us on August 13th to finally receive contact from the IBI directly concerning evidence related to William and Maureen. That after so many years of fighting for justice, we finally knew for certain that others had gained a telling insight into the traumas we have undergone. It was a huge moment.

But then try to imagine how we felt at having to simultaneously digest that very welcome (we at least hope) development, manifested in the shape of an enormous legal submission, by also realising that we had to drop everything and prepare a response in less than a week. We just want people to understand that there can be sensitivities at every turn. It comes with the territory of dealing with an injustice that has lasted so long.

Quite justifiably, the IBI can't be expected to know every eggshell and punctiliously plan around each one (e.g. it's not exactly a great time of year for us having to trawl again through the events of

August 13th-18th, 1994, almost 26 years later to the very days, for it's frankly depressing; but sometimes such things are inescapable, we realise that). But equally, like we once said to our legal counsel in 1997, and like we mentioned to the Archer Inquiry team in 2007, like we really wanted to say to the arrogance of the GMC in 2004, and like we're now asking the IBI team in 2020, there are some sensitivities that can be anticipated, using not so much common sense but common courtesy.

Asking us to digest such a mammoth document, expecting us to understand what it represents as much as what it doesn't, then leaving us to blind scope its contents and provide our response all in the space of six days was surely an entirely avoidable sensitivity. A little circumspection goes a long way. We will leave our opening point there and progress towards response.

2. Concerning any implied request for our approval

Given that a significant portion of our evidence is, presumably, being used in conjunction with that of another named witness (WITN3365023), we have intuited that perhaps we should indicate if we are content for such to be used. However, we note that we haven't necessarily been asked such. In any case, we are happy for the IBI to use, however publicly, whatever is required.

3. Concerning the numbered witness; and, if necessary, the matter of redactions/anonymity

We have not presumed how the IBI has judged the above cited evidence. All we know is that the file has been acquired and read.

We also do not know the status of the above numbered witness, who could be a fellow CBS victim and/or also a fellow complainant to the GMC; or perhaps a GMC official, or holding some other

position. We intuit that there is no need for us to know and that we have only been made privy, out of courtesy, to some of our evidence to be presumably used in conjunction with that person's case, given that there seems to be a very significant overlap.
We do not presume whether the IBI – after reading our evidence – is sympathetic to our cause in this specific regard. We also do not discount the possibility that the IBI and the numbered witness might be using our evidence in a way that is not retrospectively supportive of our historical actions. Further, we have considered also that the IBI and the numbered witness may be using our evidence entirely neutrally, perhaps to amplify an attendant issue that has arisen. We cannot know anything.

Despite all of the above caveats, we have framed our response on the basis of our own convictions; knowing the truth of our case, and about what William suffered – and subsequently Maureen. Because we saw and lived it. We will never waver from our convictions, especially as already laid before the IBI so far in Part One of our "witness statement", covering November 8th, 1968 to September 3rd, 1994, (with certain projections beyond that date) and also within the evidence file that the IBI has acquired concerning our contest against Dr Hay some 16 or so years ago.

As such, we are prepared to say this regarding the matter of anonymity and redactions: we understand the caution in removing William's and Maureen's names, however we are content for them to be used in full. There is absolutely nothing we have to hide, even should it transpire that our evidence is being used in a manner not supportive of our contentions circa 2004/05. If there is a pertinent reason, or protocol, as to why the IBI has employed such redactions, then that is no business of ours. However, if there was any implication that we might agree to the lifting of such redactions (if only for administrative ease), then be assured that we give our full licence.

4. Concerning the substance of our response

We were given no steer as to the manner of response required, if indeed any at all. As such, we have no way of knowing whether we are expected to comment on the substance or detail of the documents that we were sent. Regardless, we will take this opportunity to supply the IBI with our views concerning most of those documents supplied, especially those that we have only just seen for the very first time over the last week. We trust that our responses here, in addition to Parts One and Two (the latter still to come) of our witness statement to the IBI, will be used to form the whole body of our submitted evidence.

5. Concerning our Witness Statements: Part One (1968-94) and Part Two (1994-present)

We also take the opportunity here to inform both the IBI and Leigh Day of a significant issue that has arisen concerning the submission of what we intend to be "part two" of our witness statement to the IBI (concerning the period from September 4th, 1994 to the present). We will expand upon that frustrating development at the end of this submission, under point number 7. However, for the time being, we wish to declare here that, for reasons which will be articulated later, we have had to change the structure of our second statement submission from that which was adverted to and envisaged at the start of part one, particularly under paragraph/item "10" in that now signed (in March 2020) document. Generally speaking, we will need to curtail the strict chronological sequencing of our evidence submission at the point when our justice campaign reached December 31st, 1997.

However, subsequent to the inclusion of pertinent chronological materials right up to and including that point – which incidentally will cover the practicalities and issues that we faced between

November 1994 and September 2nd, 1997, i.e. leading to the collapse of our first intended pursuit of medical negligence against Dr Hay – we will still advert to the main headline issues that we referenced at the start of part one of our statement. However, we will have to do so in the form of a more fluid and consolidated narrative, almost as an annexe, as it were, covering those main issues that we still wish to highlight – indeed right up to the unfortunate, and entirely avoidable, experience that we endured on August 13th, 2020. We anticipate being in a position to submit this second part of our statement before the end of September 2020. Although we will be flagging up the key issues that we have encountered (almost exclusively in the negative) between January 1st, 1998 and the present, we wish to stress that if the IBI would ever require supporting documentation to back-up our claims (e.g. what we intend to say about the Archer Inquiry, circa 2007, or our communications with the former MP and UK Health Secretary, Mr Andrew Burnham, in September 2012) then we would be only too happy to supply them.

As said, we will explain our, quite distressing, reasons for this change of course later in this document (it may also be an issue that the psycho-social team at the IBI would wish to focus on). In the meantime, though, we wish to record an apology to the Chairman and the IBI team for our (unavoidable) inability to maintain the strict pattern of evidence that we very intentionally embarked upon at the start of our statement right through to its conclusion. It is a huge disappointment to us that this should be so.

6. Our opinions on the documents submitted to us on August 13th, 2020.

6.1

We do not know whether the specific, non-chronological order in which the documents were submitted to us last week was intentional (it made our evaluation somewhat difficult). We understand, also, that certain documents have been withheld; there were obvious sequencing gaps.

Regardless, we have structured our responses in chronological order. Our references to page numbers have followed the IBI's numerical sequencing, i.e. the pattern identified by the "WITN0000000_00-00" type labels. Where possible we have also, for ease of identification, referred to the documents that we wish to comment on by using their native titles, e.g. "*Case Screening Memo*".

Accordingly, then, and as far as we could tell, we were sent the following, which we have parsed by the following descriptions and dates:

01. Maureen's initial, hand-written letter to Tim Cox-Brown; 16/03/04;
WITN3365023_001-32

02. Maureen's letter to Tim Cox-Brown and supporting materials
(e.g. "*The Case against Dr C. R. M. Hay*"); 31/03/04;
WITN3365023_001-51 thro 54

03. "*Memo from Tim Cox-Brown to Dr Brian Keighley*"; 08/04/04;
WITN3365023_001-30 thro 31

04. The Medical Protection Society's letter to Tim Cox-Brown; 28/05/04;

WITN3365023_001-55 thro 57

05. Maureen's letter to Tim Cox-Brown; 15/06/04;

WITN3365023_001-58 thro 86

06. The Medical Protection Society's letter to Tim Cox-Brown; 09/07/04;

WITN3365023_001-87 thro 90

07. "*Casework Screening Memo and Screening Decision Form – Part 1 - Caseworkers to complete"* (signed by Mr Tim Cox-Brown); 16/08/04;

WITN3365023_001-24 thro 29

08. "*Casework Screening Memo and Screening Decision Form – Part 2 - Screeners to complete"* (signed by Dr Sarah Whiteman); 16/08/04;

WITN3365023_001-16 thro 19

09. "*Casework Screening Memo and Screening Decision Form – Sections 10-12"* (signed by anonymous lay screener); 17/08/04;

WITN3365023_001-20 thro 23

10. "*Case Examiner Decision Form – Parts 1-5*" (signed by Mr Tim Cox-Brown); 14/02/05;

WITN3365023_001-2 thro 7

11. "*Case Examiner Referral Form – Sections 1-8*" (signed by Mr[redacted];

14/02/05;

WITN3365023_001-8 thro 15

12.[redacted]s letter to Maureen; 30/03/05;

WITN3365023_001-91 thro 93

We have also referenced other pertinent documents that were not in the file submitted, namely:

A1. Tim Cox-Brown's letter to Maureen; 29/03/04

A2. Tim Cox-Brown's letter to Maureen; 07/04/04

A3. Tim Cox-Brown's letter to Maureen; 30/04/04

A4. Tim Cox-Brown's letter to Maureen; 02/06/04

A5. Tim Cox-Brown's letter to Maureen; 21/06/04

By our reckoning, the whole period of our postal correspondence with the GMC spanned from 16th March, 2004 to 30th March, 2005. We are not aware of any written communications prior to, or post those dates.

6.2

To the best of our recollection, the very first contact we made with the GMC was via an exploratory telephone call from Maureen to Mr Cox-Brown at some point shortly prior to March 16th, 2004. This was supplemented by her hand-written letter, enclosing relevant introductory materials, as described, dated March 16th, 2004 (WITN3365023_001-32 thro 50), all of which appear to have been received at the GMC on March 22nd, 2004.

6.3

On March 29th, 2004, Mr Cox-Brown sent his first response to Maureen (A1; i.e. not in the PDF file submitted on August 13th, 2020). We have transcribed it (bold emphases in original; our italics):

> *29 March 2004*
>
> *Dear Mrs Murphy,*
>
> ***Re: Dr. Charles Richard Morris Hay***
>
> *Thank you for your letter of 16 March 2004 about Dr Charles Hay, which we received on 22 March 2004. Please accept my apologies for my delay in responding.*
>
> *I have enclosed a leaflet which explains our remit and how we assess complaints that I hope you will find helpful. It is important that you read it so that you understand from the outset what we can, and cannot, do.*
>
> *You have asked for my comments on the documentation enclosed with your letter. I am afraid that I cannot offer my opinion on this information. The role of the GMC is to maintain the medical register and we can only take formal action against a doctor in response to a complaint about a doctor's conduct or performance, where there is information which suggests that his or her behaviour or conduct has been so poor that removal or restriction of his or her right to continue in medical practice may be justified. The Medical Act 1983 (as amended) describes behaviour of this sort as 'serious professional misconduct' ("SPM") or 'seriously deficient performance' ("SDP").*

In order to assist us in the consideration of your complaint it would be helpful if you could provide the following information:

1. *A complete consent form (blank form enclosed). I should explain that no decision has yet been made about whether we can take action on the matters that you have raised. If you answer 'no' to any of the questions on the form we will be unable to consider your complaint further. Please ensure that you enter the names of all the doctors you wish to complain about on this form, if it is the case that you have complaints about doctors other than Dr. Hay.*
2. *It is not clear which doctors you wish to complain about, although we have assumed that your complaint concerns only Dr. Hay. I should therefore be grateful if you would provide a detailed account of your specific allegations against each doctor you wish to complain about (including dates, wherever possible), together with any further supporting documents you may have. Please put your complaint about each doctor on a separate sheet of paper.*
3. *Copies of all correspondence relating to any previous complaints you may have made to other organisations on this matter.*
4. *Copies of all of your late husband's relevant medical records (if you have them).*
5. *Completed medical records consent forms to enable us to request copies of your late husband's records in the event that you do not have copies yourself. I have enclosed blank forms for completion, and I'd be grateful if you would ensure that you enter the addresses of the places where your late husband's medical records may be held, such as the GP surgery and the hospital(s) where he received treatment for haemophilia.*

> *Please provide the information I have requested above within seven days of the above date,* ***i.e. by 5 April 2004****. As soon as we have received this information from you we will refer your complaint to a member of the General Medical Council who will decide whether our involvement is merited. We have to do this, as the Rules which govern our fitness to practise procedures do not generally allow us to take action where the events giving rise to a complaint occurred more than five years ago.*
>
> *Please do not hesitate to contact me should you have any further queries on this matter.*
>
> *Yours sincerely,*
>
> ***Tim Cox-Brown***
>
> ***Caseworker, Fitness to Practice Directorate***
>
> […]
>
> *Enc.*
>
> 1. *Leaflet explaining GMC complaints procedure.*
> 2. *Consent forms.*

The above was postmarked "*29.03.04*", sent first class from "*Manchester*". It therefore would have reached Maureen, at the earliest, on Tuesday, March 30th, 2004. Including that date, we were then given just four days, maximum, to access, compile, and return all of the requested documentation in order to post, first class, a response by circa midday on Saturday, April 3rd, 2004, to ensure it reached the GMC offices as required by, in bold lettering, "**5 April 2004**". In any case, the materials in question – given the extent of William's medical records – would need to have been sent by parcel post. Furthermore, given the sensitivities of the documents (and by 2004 we were well aware of how often medical records concerning the CBS regularly seemed to "*go missing*") we did not wish to risk placing William's files under the care of the Royal Mail.

It was the first instinct we had that the complaints system was stacked against complainants. For it was surely completely unreasonable, especially given the complexities of William's case, to expect us to fulfil all that was requested of us within a timescale that spanned: i) half-day (at most) on Tuesday, March 30th (i.e. the day of receipt); ii) Wednesday 31st March; Thursday 1st; and Friday 2nd of April; iii) and then the morning of Saturday, April 3rd, in order to catch the weekend post to ensure a Monday morning delivery, even if we were prepared to use that dispatch channel.

These are the all-too-easily hidden and forgotten aspects of the CBS that have dogged campaigners for decades. Given the rank unfairness of the GMC's request, and our experiences of fighting for justice during a decade or more at that point, we were also wary of three other potentialities. Firstly, that, even if we had been prepared to use Royal Mail or other channels, even a slight delivery delay could – and probably would – have been used by the GMC as a time bar against us. Secondly, we had a fear that even if materials were safely delivered on time, that documents could still have easily "*gone missing*", or non-receipt may have been claimed (by 2004, we had long learned to trust no-one; we still don't). Thirdly, we anticipated that the GMC might even have cited that it required delivery of materials "*by*" April 5th, 2004 not "*on*" April 5th, 2004.

As a consequence of all the above ultra caution-erring – borne of bitter experience – we felt that we had no choice but to reduce what seemed an already impossible timetable even further by committing ourselves to hand-delivering the required materials to the GMC offices in Manchester (a 70-mile round trip, door-to-door) on Friday, April 2nd, 2004, so ensuring that: i) we could see the documents safely delivered to Fountain Street ourselves and gain a receipt; and ii) the GMC could not either cite late delivery nor even use any arbitrary "*by*" not "*on*" deadline technicality.

Bad faith existed between the parties from the outset, due to the grossly unjust timetable set by Mr Cox-Brown, which at a stroke betrayed his obvious lack of appreciation of William's case and indeed the trauma we had experienced in the previous decade or more. What would have been the problem in allowing us an extra week of preparation of materials, as opposed to strict stipulations, of less than a week, typed in bold?

Thus, an already daunting prospect became even moreso, as we literally had to drop everything we were occupied by and commit ourselves to working around the clock from the afternoon of Tuesday, March 30th, 2004 in order to hand deliver materials to the GMC on Friday, April 2nd, 2004. This explains why Maureen's covering letter to Mr Cox-Brown (WITN3365023_001-51) was dated 31st March, 2004, whilst her consent form (WITN3365023_001-52) expanding the parameters of our complaint to include "*Dr Ian Gilmore*", as well as Dr Charles Hay, was dated 2nd April, 2004 (we note that the GMC "*received*" stamp declared that her letter and materials were received on "*-2 APR 2004*").

Although we didn't make too much note of it at the time, our attention – in the wake of the IBI's document submission to us last week – has now most certainly been drawn to the final paragraph of Mr Cox-Brown's submission to us, on March 29th, 2004, of the, in his words "*Leaflet explaining GMC complaints procedure*". We reference particularly the following: "*If we decide to take no action, the complaint will be held on our files for up to three years and may be reopened if we receive another complaint about the same doctor within that time.*" The rest of Mr Cox-Brown's submission is available to the IBI, if needed.

Given the tight timetable afforded us by Mr Cox-Brown, we didn't feel that we could possibly relate the extent of our complaints against Drs Hay and Gilmore, nor adequately convey the sustained suffering endured by William from the late 1980s to his death in 1994. It wasn't the first time – nor the last – that we felt stymied in communicating the broader realities of the whole tragedy.

Accordingly, we had to do our best within the time-frame. Hence our broad brush-stroke compilations that we submitted, namely: "*The case against Dr C. R. M. Hay*" (as included in the documents sent to us by the IBI on August 13th, 2020; WITN3365023_001-53 and 54); and "*The case against Dr I. T. Gilmore*".

Given the lack of appreciation that Mr Cox-Brown implicitly communicated to us by the imposition of the near-impossible timetable we were given, we knew to be on guard against any further restrictive methods that the GMC would employ in order to sunder us. We readily admit to having already developed an ultra-defensive mindset by that stage. That said, although we had been deeply battle-scarred by the events of our curtailed potential civil litigation against Dr Hay between November 1994 and September 1997, we hadn't initially entered into communications with the GMC in such a manner. We had anticipated that we were dealing with a clean-slate. However, once Mr Cox-Brown had issued his completely un-warranted time-table, we immediately sensed the re-surfacing of the type of injustices, chronological or otherwise – borne of determined mindsets and groupthink – that had militated against us from 1994-97. We were once bitten, several times shy.

Consequently, we readily admit that we rather creatively interpreted point 3 in his letter to us of March 29th, 2004, specifically his request of "*Copies of all correspondence relating to any previous complaints you may have made to other organisations on this matter.*" Our immediate instinct was that the GMC, rather than undertaking a fresh and un-prejudiced investigation into our complaints, would immediately use the so-called "*expert reports*" acquired by our legal representatives in 1997 to work against us (from which we have quoted extensively in Part One of our Witness Statement) if we were to submit such at that stage.

As we stated several times in our statement, we were left absolutely devastated by the verdicts of the doctors that Irvings solicitors commissioned to investigate the circumstances of William's final years. We couldn't see how they could possibly have reached the conclusions that they did and not only did their verdicts all but completely undermine our case (although we maintain that we were immediately more hampered by financial and chronological factors concerning our reluctant non-pursuit of the case beyond September 2nd, 1994; a date that we assumed – until just six days ago, ironically – was always a non-negotiable deadline; more later).

Furthermore, we didn't interpret that there was anything of a statutory aspect behind Mr Cox-Brown's request for "*Copies of all correspondence relating to any previous complaints you may have made to other organisations on this matter*", given that he prefaced that point by summarily stating that such materials were being asked for "*In order to assist us in the consideration of your complaint*" and that "*it would be helpful if you could provide the following information…*".

Therefore, whilst we most certainly did not wish to immediately submit the reports commissioned by Irvings in 1997 – for we had a (correctly, as it turned out) honed instinct that they would be used as a labour-saving and quick get-out method of bringing our revitalised complaint against Drs Hay and Gilmore to a swift conclusion and that our case would be closed before we had barely begun to re-contest it – we knew we had to act with transparency. Accordingly, as can be seen by point 3 that we made in our submission to Mr Cox-Brown, we immediately adverted to the fact that we had undertaken litigation proceedings by 1997 (at the latest) concerning William's case.

In any case, given the time-constraints placed upon us by Mr Cox-Brown, which meant that we simply didn't have the scope to flesh-out our grievances against Drs Hay and Gilmore in the way we would have wished, we felt that it would be instructive for us to include within our hand-delivered submission the statement that Maureen had provided to Irvings in 1997. For although elements of it were outdated, in our view, but only insofar as our understanding of William's case had developed significantly in the years between 1997 and 2004, we felt that it would at least serve to offer Mr Cox-Brown a more-rounded appraisal of the attendant complexities than we could ever provide by our two rushed documents "*The case against Dr Charles Hay*" and "*The case against Dr Ian Gilmore*".

We knew that we were facing something of a "*first impressions count*" situation with Mr Cox-Brown. We had to implicitly signal that we could provide quality information; moreover that we could do so competently and cohesively, despite our lay-limitations; and most importantly that there was much more to William's case than first met the eye, for it most especially wasn't a straightforward case of a haemophiliac being infected with either HIV or HCV as a result of being treated with contaminated NHS blood products and then dying. Although we most certainly do not belittle those relatively, more-easily-described individual tragedies, for every single death that has occurred consequent to the CBS has been as important as another – and we state that there is no hierarchy of fatalities – we just simply refer to the fact that some of case circumstances were more easily described than others. William's wasn't one of them.

As can be seen, we enclosed Maureen's statement from the earlier, curtailed litigation, stating that: "*This document was originally written in 1997, and was used as a statement of complaint as part of a medical negligence case, conducted through my solicitors (Irvings, Liverpool) at that time.*"

It is up to others to decide if we hid anything. We've long since ceased to care about nuances or semantics. In any case, the experiences that we endured between 1994 and 1997, i.e. the failure of our initial civil litigation – which, as said, will be fully described in part two of our forthcoming witness statement to the IBI – were utterly brutal (we assert in advance that they are barely believable and that nobody should have been subject to such anxiety in the immediate years after the trauma of William's demise and death; for virtually every month that went by between September 3rd, 1994, the date of William's death, and September 2nd, 1997, the collapse of our intended litigation, opened up another scandal-within-a-scandal).

Given that our initial experience with the GMC had been the imposition of Mr Cox-Brown's equally scandalous timetable, we knew instinctively that we were facing another attritional battle and we were not likely to undermine ourselves in any way if we didn't necessarily have to (i.e. by statute), especially so early in proceedings. In any case, given our whole experience of the CBS, we make no apologies for ever employing any campaign-crafts or correspondence-smarts. We have been on the receiving end of an absolute travesty for decades now; there is simply not an inch of ground we're ever prepared to concede.

As far as we were concerned, it was up to Mr Cox-Brown to read between the lines of our declaration if he so wished. That was his job. That's what he was being paid for. We expected, however, that he would certainly do so, and that it wouldn't be too long before he would enquire if we had any further documentation relating to our curtailed litigation of 1997. We could only hope that, in the meantime, he would read the totality of our submissions – including the clear steers that we had given him concerning William's medical records – and form his own opinion before then resorting to the opinions of the so-called "*experts*" commissioned seven years earlier.

Indeed, we even dared to hope that Mr Cox-Brown, having, by his own lights, formed his own opinion of the injustice suffered by William, would eventually come to be as mystified as we had been in 1997 to read the verdicts reached by Drs Davies, Little and Machin (although the latter not as much as the two former names). We hoped that he would begin to see why we had returned to the same allegations. For we knew the strength of our evidence – it spoke for itself – and he would know that we had suffered a double injustice.

6.4

To our surprise, Mr Cox-Brown in his second response to Maureen (A2), dated April 7th, 2004, did not make any reference to other potential materials relating to our curtailed litigation of 1997. Indeed, we further dared to read-between-the-lines that we may already have cleared a significant early hurdle. Certainly, we knew that our complaint, and therefore, more importantly, William's case-story, would be evaluated by a second person within the GMC. This was important to us. For the more people within the GMC who were made privy to the details of the tragedy that befell him, the better. The more people who knew of his story, the less scope there would be to deny him justice; or so we naively believed.

Naturally, we were wary of the fact that, for the second time in his first two correspondences with Maureen, Mr Cox-Brown had clearly highlighted the existence of the "*five year rule*" (our shorthand term and punctuation). We knew, of course, that such was the biggest of the first initial hurdles that we would need to clear and that we were potentially expending energy on a pursuit that may be dismissed on such a technicality before it had barely begun. Nevertheless, as we communicated at the time, we were prepared to take that risk. In any case, Mr Cox-Brown had, by April 7th, 2004, several opportunities to block passage of our complaint on the basis of the five-year-rule and he hadn't yet done so. Furthermore, even after two key correspondences from him (i.e. March 29th and April 7th, 2004), we were encouraged that our case was still live, so to speak.

We have transcribed Mr Cox-Brown's letter (A2) here (bold emphases in original; our italics):

> *7 April 2004*
>
> *Dear Mrs Murphy,*
>
> ***Re: Dr. Charles Hay & Dr. Ian Gilmore***
>
> *I am writing further to your letter and enclosures of 31 March 2004. Please accept my apologies for my delay in responding.*
>
> *Thank you for sending me the information I requested. Your complaint will now be referred to a member of the General Medical Council who will decide whether our involvement is merited. We have to do this, as the Rules which govern our fitness to practise procedures do not generally allow us to take action where the events giving rise to a complaint occurred more than five years ago.*
>
> *I will contact you again as soon as I have more information on the progress of your complaint. Please do not hesitate to contact me should you have any further queries on this matter.*
>
> *Yours sincerely,*
>
> ***Tim Cox-Brown***
>
> ***Caseworker, Fitness to Practise Directorate***
>
> […]

6.5

It would appear from the document, dated April 8th, 2004 (WITN3365023_001-30/31) – which can be adequately described as a "*Memo from Tim Cox-Brown to Dr Brian Keighley*" – which we had never seen before, that the author, even within just a day of writing to us, and just six days after we had hand delivered our evidence to the GMC (but in reality only four working days: Monday 5th April - Thursday 8th April), was already of a mind that William's case merited a waiving of the "*five year rule*".

This doesn't surprise us. For again, we were always confident that the evidence surrounding William's case was so convincing that it only required an objective person to take adequate time to read our complaint(s) carefully, and the necessary medical records attendant to them, and so reach a conclusion that, even at the very least, an investigation into the wider circumstances should be conducted; let alone reach an overall verdict that he was the victim of a major medical injustice.

We hold that the following transcription of Mrs Cox-Brown's assertion at point 6 in his memo speaks for itself: *"It appears to me that* [Mrs Murphy's] *complaint about Dr. Hay raises some serious issues which, although they focus mainly on treatment to one person, have wider implications, and could therefore require us to pursue this matter in the public interest despite the age of the events complained about."*

We note also, from point 1 on his memo that we were not alone within the haemophiliac community in submitting complaints to the GMC. We stress that at no point in our dealings prior to, or during our contacts with the GMC, were we acting in tandem with any other parties. It did not surprise us, though, on August 13th, 2020, to learn that we were not the first to contact the medical body about matters pertaining to the CBS.

As such, it was also hardly surprising to read the hand-written notes penned across the memorandum – we can only assume that Dr Keighley was the author – which also fully endorsed Mr Cox-Brown's viewpoint, not least because the medic had dealt with three haemophiliac cases before and therefore, we presume, realised that a pattern was beginning to emerge.
Regardless, we believe that William's case, even on its own, given the circumstances involving Dr Hay and his international reputation, was strong enough to justify a waiving of the five-year-rule. Although the entirety of the hand-written note in the bottom corner has been purposely redacted, what remains visible is telling, insofar as the author clearly alludes to point 4a (according to Mr Cox-Brown's structure), *inter alia*, being pertinent to the "*issues re. Dr Hay*". We entirely concur if our interpretation is correct.

We also note two other aspects in particular, which have bearing upon our further responses later in this submission. Firstly, that Mr Cox-Brown referred to the GMC's "*Standards guidance issued in 1988 regarding the testing of patients for hepatitis C and HIV in the 1980s*". We draw specific attention to the fact that easily received wisdom is such that HCV was not identified until 1989 and that a test for the virus was not available until September 1991. Secondly, we note that specifically Mr Cox-Brown referred to William's case notes as "*voluminous*". Although that is a general term, and understandably employed, we note its use in Mr Cox-Brown's memo.

6.6

Naturally, we had no idea of the internal correspondences circulating within the GMC even just a week after we had delivered our evidence. Although we had been frustrated by the long-running fight for justice concerning the CBS – well over a decade-and-a-half by 2004, we were counter-intuitively hoping that there would be a significant lapse before we heard again from Mr Cox-

Brown after his correspondence on April 7th, 2004. We ironically interpreted every day of silence as a potential positive. For we knew that the only way that the "*five-year-rule*" would be overcome was through a thorough reading of our complaint and necessarily William's medical records (and we believed that anyone, having done so, could only reach the conclusion that our grounds were generally justified).

Thankfully, a further 23 days elapsed before, on April 30th, 2004, Mr Cox-Brown eventually re-contacted us in writing (A3). Although we were frustrated to read that our case against Dr Gilmore had been summarily dismissed (for although we had much to thank Dr Gilmore for, the fact was that he had overlooked the existence of cancer in William from at least July 25th, 1994 and had then sent him on a psychologically-tortuous wasted journey, on August 13th, 1994, to the Newcastle Freeman Hospital in the hopes of being the beneficiary of a liver transplant that was already a non-starter even before he had settled himself into the car transporting him from Liverpool), we were astonished to learn that our case against Dr Hay had overcome the "*five year rule*".

It was not that we didn't believe that such an exception to the apparent norm was merited, for we knew that of course it was. It was more that we had been accustomed to injustice and we were especially prepared for that to be so again, especially given Mr Cox-Brown's repeated references to the "*five year rule*" (as though preparing us for the inevitable) and indeed the completely unreasonable timetable that he initially set us for the compilation and submission of our body of evidence (any failure of ours to meet that harshly imposed deadline could have scuppered our chances before we had even begun).

Furthermore, although we were disappointed about the dismissed matter against Dr Gilmore, we even judged that the fact that the "*medical screener*" had obviously scoped the documents enough to discern a hierarchy of culpability between the two doctors, strongly suggested that William's case had been studied intensively. Again, we trusted that anyone spending any qualitative time assessing the materials could only reach one conclusion; that he was subject to an intolerable injustice.

Therefore, upon receipt of Mr Cox-Brown's third correspondence with Maureen, we dared to hope that, finally, an end to the long injustices and campaigning that we had suffered and endured, was potentially in sight.

We have transcribed Mr Cox-Brown's letter here (bold emphases in original; our italics):

> *30 April 2004*
>
> *Dear Mrs Murphy,*
>
> ***Re: Dr. Charles Hay & Dr. Ian Gilmore***
>
> *I am writing further to our recent correspondence regarding your complaint about Drs Hay and Gilmore. Please accept my apologies for the delay in contacting you.*
>
> *In my recent correspondence I explained that your complaint had been referred to a medical screener for a decision as to whether our involvement is merited, given that the events giving rise to the complaint occurred more than five years ago.*
>
> *The screener has now decided that we should consider your complaint about Dr. Hay, but not your complaint about Dr. Gilmore. The screener considered whether the circumstances of your complaint justified the waiving of the rule that prohibits us considering complaints where the events complained of occurred over five years ago. In your case the screener did not consider that there was an issue of public interest in your complaint against Dr Gilmore*

which would justify this. In view of this we will not be taking any further action on your complaint about Dr. Gilmore.

The screener did decide, however, that our involvement is merited regarding your complaint about Dr. Hay. As it is the GMC's policy to send copies of complaints to the doctors concerned, I have sent a copy of your complaint to Dr. Hay today and invited his comments on the matters you have raised. I should explain that, at this stage, Dr. Hay is under no obligation to comment, but should he choose to do so, I will provide you with a copy of his comments. You will have an opportunity at this point to add further comments if you wish. If you do, these comments will also be disclosed to Dr. Hay.

We will then refer the case to a screener again. Screeners are appointed to consider complaints about doctors' conduct and performance, and to decide whether the GMC can take action on them.

We will write to you again when we have any further information, but hope you will appreciate that this may not be for several weeks.

In the meantime, please contact me if you have any questions.

Yours sincerely,

Tim Cox-Brown

Caseworker, Fitness to Practise Directorate

Enc.

Leaflet explaining GMC complaints procedure.

6.7

Although you have included Ms Longstaff's response of May 28th, 2004, for the Medical Protection Society (MPS), on behalf of Dr Hay (WITN3365023_001-55 through 57), as the next chronological sequence in the correspondence chain (certainly as far as the PDF documents submitted to us on August 13th, 2020 are concerned), you did not enclose Mr Cox-Brown's covering letter (A4) enclosing a copy of such to us, as dated June 2nd, 2004.

We have transcribed it here (bold emphases in original; our italics):

> *2 June 2004*
>
> *Dear Mrs Murphy,*
>
> ***Re: Dr Charles Hay***
>
> *I am writing further to our recent correspondence.*
>
> *I have now received the enclosed response to your complaint from the Medical Protection Society (MPS) on behalf of Dr. Hay.*
>
> *It is now open to you to comment on this response if you wish. If you do, I should be grateful if you would provide me with your written comments by 16 June 2004. Any response that you make will be forwarded to Dr. Hay and the MPS to allow them a further chance to reply.*
>
> *I look forward to hearing from you shortly. Please contact me if you have any questions.*
>
> *Yours sincerely,*
>
> ***Tim Cox-Brown***
>
> ***Caseworker, Fitness to Practise Directorate***
>
> *Enc. Letter from Medical Protection Society to GMC dated 28 May 2004.*

Mr Cox-Brown's letter was both dated and postmarked as June 2nd, 2004, and sent by first-class dispatch. It therefore would have reached us at the earliest on Thursday, June 3rd, 2004. Thankfully, he allowed us 13 days to respond (if we wished), which was in marked contrast to the very first and hideous deadline he had set us in late March/early April. We saw this as progress.

We make no further substantial observations to Ms Longstaff's letter of May 28th, 2004 to the GMC, for we believe that what we submitted to Mr Cox-Brown on June 15th, 2004 (WITN3365023_001-58 through 86) still speaks for itself. We note, though, that Ms Longstaff in her seventh paragraph, wherein she contradicted herself, used the term "*voluminous*" in reference to William's medical records, despite then saying that only a "*few*" had been produced. We only make reference because, as we remarked, at point 4 above, Mr Cox-Brown had also correctly described them as "*voluminous*". Again, we understand that such is a general term but nevertheless we wondered at the time (as proven by the contemporaneous correspondence) as to how Ms Longstaff knew that the medical records (which we submitted to the GMC) were indeed so voluminous, despite Dr Hay having only seen the "*few"* that at that point had "*been produced*". It just seems notably coincidental to us that the same term kept getting used.

6.8

Not included in the documents sent to us on August 13th, 2020, was Mr Cox-Brown's response (A5) to our submission to him – and by extension to Dr Hay and Ms Longstaff on June 15th, 2004 – replying to the MPS's communication of May 28th, 2004. It was an important letter. We trust that the IBI had reason for not including the correspondence in the evidence submitted to us last week.

We have transcribed Mr Cox-Brown's letter, dated 21st June, 2004, here (bold emphases in original; our italics):

21 June 2004

Dear Mrs Murphy,

Re: Dr Charles Hay

Thank you for your letter of 15 June 2004 in which you have commented on the response to your complaint provided by the Medical Protection Society on behalf of Dr. Hay.

I have sent copies of your latest correspondence to Dr. Hay and the MPS today, who now have a further two weeks to provide final comments on your complaint if they wish.

I note from your correspondence that you have said that you have an expert report obtained as part of your previous legal activities regarding this matter. I should be grateful if you would send me a copy of that report as soon as possible, as well as any other relevant documentation, as it may be useful to us in our consideration of your complaint.

I will contact you again once I have more information on the progress of your complaint.

Yours sincerely,

Tim Cox-Brown,

Caseworker, Fitness to Practise Directorate

To be absolutely clear, it was Ms Longstaff who had raised the issue of, using her quotes, "*an independent expert report*" having been "*obtained*" – according, she said, to Dr Hay's "*understanding*" – and she did so in her correspondence to the GMC of May 28th, 2004. She had stated that "*Dr Hay understands that Mrs Murphy had the benefit of legal advice and assistance in investigating that claim*", namely of "*damages for medical negligence*", which were "*originally made in 1997*".

Given that, by May 28th, 2004, we hadn't yet disclosed the existence to Mr Cox-Brown of the so-called "*expert reports*" acquired by our solicitors in 1997 – merely that we had indeed sought to pursue litigation in that year, which we had never hidden and even provided him with the statement we made to our legal team in that respect – we wonder as to how it was that Dr Hay "*understood*" that such an expert report was indeed raised. Further, it was interesting that he understood such to be in the singular. For there were actually three reports produced. We'd venture to imagine that surely he would rather have cited "*reports*", in plural, to support his (correct) presumption that they were all "*unsupportive*" of our claim against him, rather than just one document alone.

As far as we understood at the time, at no point did our solicitors between 1994 and 1997 inform Dr Hay of such a potential litigation occurring; although we stand to be corrected – indeed if that is a legal requirement, even in the investigation/research phase. Certainly, the document records that we have retained covering the three years of correspondence between ourselves and Irvings solicitors (which will be recorded in part of our witness statement to the IBI) do not state that Dr Hay had necessarily been made aware of such a potential case being raised against him.

We knew that, in addition to our legal team knowing that Dr Hay was the subject of a potential medical negligence claim, both the Benefits Agency-Legal Aid Board and then Maureen's insurers, Hambro, were initially the only other parties aware of our intention to raise such a named case against a specific doctor. Eventually, and beyond the wider personnel of our legal team – e.g. those at chambers – the only other group of individuals that we were aware knew of the potential of a case against Dr Hay were the three "*experts*" reviewing William's case: Drs Davies, Little and Machin.

If it wasn't the case that Dr Hay necessarily needed to be informed by our legal team in the period between November 1994 and September 1997 of the potential of a case ever being lodged against him – and we expect that the IBI would be able to clarify that – then we wonder as to how he came to "*understand*" (a telling term; i.e. he apparently claimed not to "*know*", but merely "*understood*") that an "*expert report*" (singular) had been produced, presumably referring to the studies undertaken by at least one of the above doctors.

It was only after Ms Longstaff had directly adverted to the "*understanding*" that an "*expert report*" had been produced that Maureen then finally had to place the existence of such on record, and to challenge the allegation that she had "*hidden*" this. We therefore duly had to supply the materials, although we do not have a copy of our accompanying correspondence; we trust that the GMC still has that communication in its archives.

Although we were reluctant to submit the so-called "*expert reports*" from 1997 – and we have spoken at length about our outright contempt for them in part one of our witness statement – we were nevertheless not as perturbed as we otherwise would have, had we been asked to submit such materials at the start of our correspondence with the GMC. For our initial reserve in disclosing the existence of the 1997 reports had proved our point, insofar as Mr Cox-Brown and other screening individuals had conducted a completely fresh evaluation of William's case, free of any prejudice that recourse to the reports of Drs Davies, Little and Machin would surely have influenced. Moreover, we knew that our strategy had been successful in steering William's case beyond the "*five year rule*" and we interpreted Ms Longstaff's tones in her communication of May 28th, 2004 as something of a desperate, last-ditch action knowing that she was speaking after the matter had been decided (or so we thought) and that the case would progress further.

We now see, though, that we should have been very perturbed at having to submit the reports of Drs Davies, Little and Machin. For it is even more abundantly clear now, subsequent to our receipt of the documents sent to us on August 13th, 2020, than it ever was in March 2005 – i.e. when our case was finally rejected by the GMC – that the whole matter was then turned on its head almost as soon as we disclosed the reports from some seven years earlier. As we'd always feared.

6.9

We were of the understanding that Ms Longstaff and Dr Hay would be granted the final word in the correspondence exchange and the natural corollary of that was that we would have no right of reply. We do not recall, though, whether we were to be denied or allowed sight of any further submissions forthcoming from the MPS to Mr Cox-Brown. In any case, we were still un-concerned because, as far as we were concerned, William's case had justifiably overcome the "*five year rule*" and it would therefore progress, despite any further, probably to be expected, protestations from Ms Longstaff. Once again, we knew the strength of our complaint and believed that it would progress through all the various stages, thus proving that he had been a victim of major medical negligence.

We could never have imagined at that stage that we then would not hear again from the GMC for a further nine months and that when we finally did so it would be to inform us that our case had failed and that the explanations provided were – and we state this unequivocally – a tissue of lies.

We read Ms Longstaff's egregious final reply (as far as we can tell, anyway) to Mr Cox-Brown, dated July 9th, 2004, for the very first time only last week. We would like to impress upon the IBI that we were absolutely devastated to see what she had written and to realise that her words – which we now realise so heavily influenced the outcome of the case – were withheld from us (whether rightfully as a matter of protocol or not) for over 16 years. This point goes to the wider matter we addressed in the *Preamble*. It was not a psychologically insignificant moment for us to read Ms Longstaff's unpardonable submission to Mr Cox-Brown. That factor should have been anticipated by the IBI and accordingly it should have been considered prior to the unfair imposition of a six-day only response timetable.

We note that Ms Longstaff deliberately skewed Maureen's references, as made in her correspondence to Mr Cox-Brown of 15th June, 2004, regarding the prior matter of him having alerting us to the existence of the "*five year rule*" on two earlier occasions (i.e. in his first two responses to our submissions). It would have been remiss of him not to have prepared us for the possibility that our case might not progress on that technicality alone. That was simply all that Maureen was referring to when she had stated that she could "*entirely understand Ms Longstaff's recourse to the 'five year rule' which she seeks to do throughout her response, as reason for non-referral - indeed I fully expected her to cite such, which was first drawn to my attention by yourself in your correspondence to me of 29th March 2004 and again on 30th April 2004*".

Ms Longstaff appeared to seize the opportunity to make the above seem sinister. We do not know Mr Cox-Brown's reasoning for (apparently) withholding the relevant correspondence from her but nevertheless, having decided on his course of action, we do not see that he acted improperly, although we are merely lay-observers.

It had been starkly obvious to us from the earlier correspondence of Ms Longstaff (that we had been made privy to) that she seemed determined not to address the substance of the allegations we made concerning Dr Hay. Instead she only seemed to be set on addressing technicalities, protocols, procedural matters and regulations. We do not say that such are unimportant; only that it was conspicuous that she seemed only to address such issues. We now see that her final response to Mr Cox-Brown extended that trend significantly.

We note that she complained about Mr Cox-Brown's apparent assertion that William's case should proceed so that the matter could be seen by "*fresh eyes*". It is therefore gratifying to glean that Mr Cox-Brown, certainly at least at that stage, indeed saw the importance of applying renewed objectivity to any review of William's case. We had feared all along that the complexities were such that it would be all too easy for reviewers or screeners to consider what we regarded as the flawed reports of Drs Davies, Little and Machin from 1997 and take their cues from their submissions.

All we had ever required from the GMC was that "*fresh eyes*" addressed the multi-layers of our complaint, without prejudice. It seems that by at least July 9th, 2004, such an over-arching standard was still being applied at the GMC. It is also clear, though, that Ms Longstaff – or rather Dr Hay – feared such a process of objectivity. It is obvious as to why, for our allegations were so damning and so completely supportable by virtue of the evidence supplied.

Accordingly, we view that Ms Longstaff's appeal for "*natural justice*" was hypocrisy of the lowest order. The very last thing that she seemed to be concerned about – especially given the rest of her letter which we will address further – was "*natural justice*". Indeed, we doubt, despite her professional abilities, that she even knows the true meaning of such a concept.

We note especially point 3 of Ms Longstaff's review of Maureen's correspondence to Mr Cox-Brown of 15th June, 2004, specifically that "*Dr Hay is not seeking to attribute blame whatsoever*", presumably in reference to Professor Shields' involvement in William's care at a specific point in

March 1993. We assert, however, that blame spreading was exactly what Dr Hay/Ms Longstaff were trying to achieve.

Had we been made privy to her letter 16 years ago, we would have underscored how such lowness was a regular characteristic trait of Dr Hay's. His dissembling was a frequent feature in the evidence we have already submitted to the IBI and we pointedly reference the comments we made in part one of our witness statement, circa paragraphs 885.3 to 887.1. It came as no surprise to us last week to learn that, some 16 years ago, Dr Hay's counsel was seeking to apportion blame to Professor Shields whilst simultaneously stating that such was not the intention. This type of base gambit has always been a behavioural signature of his. It was actually William who long ago got his measure.

We note from point 4, that Ms Longstaff asserts that "*Dr Hay firmly refutes these allegations, and believes they are unfounded.*" Yet, as far as we can see, she never once in any of her correspondences stated as to why. As said earlier, her only recourse was to matters of procedure. Her responses to the GMC were only ever exercises in passive-aggressive deflection, to force attention away from the real and very serious substance; a particular tactic of hers – in addition to blame apportioning – being to denigrate the actions or intentions of others. We would aver, then, that Ms Longstaff and Dr Hay seem to have formed a very suitable and simpatico client/counsel partnership.

Ironically, at point 6, Ms Longstaff has inadvertently been of considerable retrospective help. She states that she was unconvinced about the reasoning we employed in early September 1997 not to progress with our first legal attempt to prove that William had been a victim of medical negligence at the hands of, at least, Dr Hay. That is/was her prerogative. In fairness, she cites some valid points that we were completely unaware of until last week. We will only state here that: i) our previously stated reasons for curtailing our legal activities in late 1997 were and remain the truth; and ii) we have yet to supply evidence to the IBI concerning the period leading up to the cessation of our legal pursuit in 1997 and will merely state for the time-being that Ms Longstaff has provided much valuable information which shines a very keen light on the questionable advice we were afforded some 23 years ago.

We read the contents of Ms Longstaff's point 8 with sheer disbelief. What she said was utterly unacceptable and cowardly, especially given that she knew she was being granted the last word and that we likely would never read her distasteful and, we would argue, unprofessional guile. Tellingly, she chose not to include the poison that she finally submitted to the GMC in the earlier correspondence that she knew we would see. Conversely, we'd quite like her to see our very belated reaction here to her appalling standards from 16 years ago.

We will first address the spurious issue of timing that she referred to, insofar as Maureen had asserted that it had only been 10 months or so prior to her first approaching the GMC that we had ever learned of the possibility of progressing a medical negligence complaint through that particular channel. Ms Longstaff states that "*this may well have been the case*". Well, it was. However she then seeks to persuade the screener of a more "*comprehensive answer*" (to what question, precisely?) in that regard, as though the timing of our decision to first make preparations to approach the GMC was even a factor to consider anyway. More deflection.

We will address the unpalatable substance of her supposed "*comprehensive…answer*" in due course. For the moment, though, we simply address the time period in question, specifically of some 10 months prior to March 2004; roughly, then, the spring period of 2003. The "*answer"* to the un-asked question as to why we only first considered having recourse to the GMC from that period onwards was far more historically prosaic than Ms Longstaff's toxic allegations imagined. For in the period from circa March to June 2003, we all acquired wireless, domestic broadband and suitable devices to exploit such connectivity. Suddenly a new paradigm in campaigning for justice and accessing information had opened up. It really was that simple.

We would explicitly point to the two uses that Ms Longstaff makes to "*ten months ago*" in her point 8. She first referenced it in consideration to the period prior to Maureen's first approach to the GMC in March 2004; again the spring of 2003. She then makes a second reference to a period 10 months prior to the date of the letter she was in the process of writing on July 9th, 2004; i.e. circa September 2003. Yet, through a sleight of keyboard, she sought to seamlessly imply that both of her citations of "*ten months ago*" referred to the same point in time, when in actual fact she was referring to two events some five or maybe even six months apart.

We wonder whether the GMC screener whom she was so clearly trying to pressure into a reversal of decision – and evidently successfully so – ever spotted this clever deception? We will say that we only did so because we have long since learned to scrutinise every single word pattern and formulation used in any correspondence relating in particular to Dr Hay. For there are always elements between the lines whenever he is concerned.

There can be no denying that essentially Ms Longstaff accused Maureen – and very "*comprehensively*" so – of being only financially motivated rather than seeking justice; i.e. reacting only to the scandalous decision made in late August 2003 by the Rt Hon. John Reid, Secretary of State for Health, in driving a further wedge between the haemophiliac communities blighted by the CBS.

We're perversely re-assured that Ms Longstaff and by proxy Dr Hay – and by extension the GMC – were aware of this indefensible tactic of the Labour government of the day and particularly how it affected Maureen. For not only had she suffered the long trauma of William's suffering consequent to the CBS, but she then endured, for almost a decade by 2003, the completely unjust discrimination meted out to her as a so-called "*Hepatitis C widow*" and therefore not being considered worthy of financial assistance from the government in the way that so-called "*HIV widows*" were. Then she was left reeling from a triple blow after being informed by Dr Reid that she wouldn't even qualify for a revised scheme of compensation because, essentially, William had died too early, i.e. prior to September 2003. She was running out of stools to fall between.

Really speaking, in order to have ensured that Maureen didn't face a prolonged and financially challenged widowhood, William should have had the foresight to not be infected with contaminated blood products in the first place and so not being forced into early retirement and then suffering a pension-decimating early death thereafter. However, having been so blighted, he should have then at least have ensured that he acquired HIV and not just Hepatitis A, B and C, and thereby ensuring Maureen qualified for assistance through the Macfarlane Trust, which of course she was denied. Nevertheless, having been so careless on both of the two aforementioned counts, he finally should have been alert enough, at the third time of asking, to have stayed alive at least until September 2003 in order to pass Dr Reid's despicable test. We trust that the IBI has plans to bring Dr Reid before its questioning process and therefore we are ironically and belatedly grateful to Ms Longstaff for providing us – albeit from some 16 years ago – with the opportunity to now flag this up in our response here.

The above is a potted summary – using very dark sardonicism as a long-honed coping tool – of the rank injustice meted out to William and Maureen over several decades now. However, for Ms

Longstaff to even dare to exploit that suffering in order to protect her client is perhaps the lowest standard of ethics we have ever encountered in all our dealings as we have fought for justice over these last few decades. Anyone who has read the evidence we have supplied to the IBI thus far will know how strong a statement that is; for Ms Longstaff has very stiff competition (we could cite Baroness Cumberlege's address to the House of Lords on March 15th, 1995 – which will be extensively scrutinised in part two of our witness statement to the IBI – made in direct reference to William's case, as a very close second). Ms Longstaff's vulgarity in stating that it "*will be put no higher than that*" in suggesting the possibility that "*concern*" about Dr Reid's "*compensation scheme*" was in part a "*precipitating factor*" (!) behind Maureen's approach to the GMC was unspeakably low. We trust that she is proud of having used such base, rhetorical tactics.

We appreciate that there is likely little justification in calling for Ms Longstaff to appear before the IBI but would suggest that somewhere along the line she must surely have transgressed some code of practice or standard of professional ethics. We simply have to leave it there, so bad has our reaction been to reading her words withheld from us (for whatever reason) these last 16 years. Except to say that it is little wonder that our fight for justice has lasted as long as it has given the prevalence of prejudiced attitudes like hers to the wider suffering of CBS victims like William and Maureen. And we recall that she even dared to cite "*natural justice*" earlier in her letter to Mr Cox-Brown. Rank hypocrisy.

6.10

We note the document that can be described as the "*Casework Screening Memo and Screening Decision Form; Part 1 – Caseworkers to complete*" (WITN3365023_001-24 through 29), as dated August 16th, 2004, and signed by Mr Cox-Brown, although we confess to being unable to entirely comprehend it.

Specifically, we do not know what to make of the matters related by Mr Cox-Brown in Section 2, concerning "*previous history*" of allegations against Dr Hay. It appears initially that there was "*none*". However, he then he goes on to describe one such case in Section 3, point 1, with the reference number *2003/0206*. To the best of our ability we discern that there seemed to be a pedantic distinction between lodged "*previous*" cases and lodged "*current*" cases, such that even if the latter hadn't yet been finalised it therefore couldn't be classed in the former category. Yet, as Mr Cox-Brown notes, the other "*current*" case, which appeared to pre-date ours – and by definition was "*previous*" – has already been subject to a decision to "*be closed with no further action*". It seems to beg the question as to when a "*current*" case could ever be considered to be "*previous*"; the answer seemingly being not until it's officially closed, even if the decision to do so has been made.

We refrain from further attempts to understand GMC logic. Except to add that we note that it was a GMC standard – as conveyed in a leaflet sent twice to us by Mr Cox-Brown – that if it is decided "*to take no action, the complaint will be held on our files for up to three years and may be re-opened if we receive another complaint about the same doctor within that time*". Accordingly, if the other case classed as "*current*", but not "*previous*" – but to be closed, but not yet, at that point – did actually pre-date ours, and within that three-year period, then our allegations would surely have necessitated its re-opening. We would have thought, anyway. Yet it doesn't appear that Mr Cox-Brown makes any reference as such. We note, though, that Maureen's case was prefixed by the GMC with the digits "*2004*", perhaps coincidentally the year that she made her formal allegation. We note that the other "*current*" but not "*previous*" case had a prefix of "*2003*".

We note that at point 1, Mr Cox-Brown again referred explicitly to the existence of a document described as "*our Standards guidance issued in 1988 regarding the testing of patients for hepatitis C and HIV in the 1980s*". We again only emphasise this reference, which we hold to be conspicuous by inclusion, given that we were later told by the GMC that one of the reasons for dismissing our case was that "*the Hepatitis C test only became available in late 1991 and Dr. Hay began testing* [William] *in early 1992*". We'd very much like to know, then, as to what the GMC "*Standards*" of 1988, in this specific regard, as twice cited by Mr Cox-Brown, actually stated. We note that such wasn't included in the evidence submission sent to us last week.

We don't know how to interpret the compartmentalised mini-narratives described by Mr Cox-Brown in "*Section 4 - Summary of Allegations*", and then the four titled columns to the right of each abstract. The status of each is ambiguous to our interpretation; for it seems that he may simply be paraphrasing our allegations, rather than reaching his own conclusions (and we suspect we are right in that observation); however we have no idea if he is declaring each of them to be "*sub-standard treatment*" or whether that would be the status of such were each instance to be proven. As to what the references to "*SPM by definition?*", "*SPM by discretion*", and "*screening test met*" qualitatively mean – other than our knowing the definitions in question, e.g. "*Serious Professional Misconduct*" – is a matter beyond our interpretative capabilities, meaning we cannot make qualified comment. Nevertheless, the narrative presentations made for informative reading.

We note that at Section 6, Mr Cox-Brown was clearly still of the view – at mid-August 2004, i.e. a full month after Ms Longstaff's repugnant letter to the GMC dated July 9th, 2004 – that Maureen's allegations "*clearly reach the threshold of SPM*" and which "*are properly arguable*". Unequivocally, he states that the "*public interest requires*" that our case against Dr Hay should proceed to the PPC despite the events being over five years previously. We note, therefore, that he hadn't necessarily been influenced – at that point – by Ms Longstaff's aggression.

6.11

We note that the document (WITN3365023_001-16 through 19), described as the "*Casework Screening Memo*", signed by Dr Sarah Whiteman, on 16th August, 2004 – the same day that Mr Cox-Brown submitted his "*Casework Screening Memo and Screening Decision Form*" – was one of the two seminal submissions that not only fundamentally changed the direction of what had until then been a progressing case of ours, but also established certain familiar phrases and false narrative structures that were thereafter writ large within the GMC's further materials relating to William.

Dr Whiteman's assertions are almost all highly objectionable. In her compilation of "*section 7/ Reasons*", we noted many major falsehoods and inaccuracies. We could perhaps write a document as half as big again just critiquing her opinions. Instead, for obvious time-constrained reasons, we restrict ourselves to these few.

Regarding her treatment of "*allegation 1*", we reject every word of her first sentence. We would refer to what we contend was a comprehensive destruction, given in part one of our witness statement, of any suggestion that Dr Hay, between 1987 and January 1992 acceptably and adequately "*monitored William's condition (clinically and via blood tests regularly)*". If so, then we would not only ask as to why William's Hepatitis C status, or even high-risk level, didn't appear on any medical records prior to his knee operation in December 1991, but also as to why nobody even suspected that he was a chronic sufferer of HCV (despite the fact that he was known to have had Hepatitis Non-A, Non-B by 1981 at the latest, as well as prior infections with Hepatitis A and B by 1978 at the very latest), let alone enduring cirrhosis of the liver; and further as to why nobody ever once imagined so even for several weeks after his post-operative recovery started to seriously falter over the Christmas period of 1991/92?

Even by his own admission, Dr Hay did not know the "*severity*" of William's liver disease prior to the 1991 operation and concedes that he known he would not have approved surgery. As we pointed out in part one of our witness statement, the surgery of December 1991 was originally planned for August of that year before being mysteriously cancelled. The very fact that Dr Hay didn't even remotely suspect that William – having contracted Hepatitis A, B, and Non-A, Non-B by 1981 at the latest – had gradually developed cirrhosis of the liver by late 1991 is proof in itself that he wasn't "*monitoring*" his patient's condition.

The clipped second sentence of Dr Whiteman's treatment of "*allegation 2*" is actually darkly risible; wherein she states that: "*The issues of prognosis were not fully understood, so treatment options limited*". Really? Which issues of prognosis were not fully understood? The likelihood that a haemophiliac, having been knowingly exposed, since circa 1968, to contaminated blood products, and having long since been infected with Hepatitis A, B, and Non-A, Non-B, would be at serious risk of developing cirrhosis of the liver, and then a whole litany of associated complexities, and then cancer and almost certain death?

Dr Whiteman's treatment of "*allegation 5*" is the first clear evidence that the premises set by Dr Davies in his so-called "*expert report*" in 1997 was beginning to be relied upon as definitive. That had long been our biggest fear. That the "*fresh eyes*" we hoped could be trained on a re-evaluation of William's case would lazily submit to the deeply flawed prior submission of Dr Davies.

Following last week's evidence submission to us, we can now see that such was already the case by August 2004; not even six months after we had first lodged our complaint to the GMC. It is devastating to know that the whole period thereafter, until the end of March 2005, was likely dominated by Dr Davies' viewpoints. It is also indigestible to now realise that Ms Longstaff had already won the day, as it were, as early as August 2004; and that, really, from the very moment that we had no choice but to transparently submit the erroneous reports we had received seven years earlier, William's case thereafter never stood a chance against the mindset of Dr Davies and the recycled groupthink of GMC officials.

Finally, concerning "*allegation 5*", Dr Whiteman refers to the "*rare complication of hepatoma*" in a multi-infected patient like William. It frankly defies belief that she could ever have reached that conclusion objectively by having throughly consulted the materials submitted. It is our contention that it is highly likely that, from the moment she and others received the so-called "*expert reports*" from the likes of Dr Davies, she ceased to conduct any further investigations or research of her own.

Concerning her treatment of "*allegation 6*", Dr Whiteman submitted a factual lie. There's no other way to describe that and we don't apologise for using such a strong term. It was most categorically and provably not true that William "*was referred*" to Dr Gilmore (and then not even by Dr Hay, but rather Dr Mark Hartley, but she conveniently omitted that) "*at a stage when the hepatoma was diagnosed*". That simply did not happen.

Furthermore, even if she'd relied on Dr Davies' flawed report, she could still never have reached that completely false conclusion. For Dr Gilmore, despite having had oversight of William from June 1994 onwards had no idea that he had already long since developed cancer (probably much earlier in 1994, likely by March) until he was informed of such, via telephone, by the medics in Newcastle on August 18th, 1994. So how did Dr Whiteman even begin to reach the verdict that she did in this specific regard, one which evidently held enormous sway over the future course of our complaint to the GMC? On what basis did she reach her assertion?

We would contend that if she is able, then Dr Whiteman should be questioned about this precise matter by the IBI. We note that she is currently an active GP in the United Kingdom and likely fit to appear. The bottom line is this: in 2004, she contrived a complete falsehood in her work for the GMC and then disseminated it. We would submit that it was the very definition of lying.

Regarding Dr Whiteman's treatment of "*allegation 7*", we can now begin to see where the repeated canard concerning the increase of William's alpha feto-protein levels from circa 9000 to 100000 first arose (although we have never been sure of the comparative metrics, as described in part one of our witness statement); as though it were somehow defensible in this case anyway. We would ask as to why she only referred to the more esoteric AFP levels and didn't describe the more readily understandable comparative mass sizes of William's liver tumour between July and August, 1994, specifically 6.5cms and then 7cms? Would it have been because she knew such a stark picture would be so damning, i.e. that neither Drs Gilmore nor Hay – despite holding co-consultancy over such an intensively tested patient as William, who was in hospital for virtually the entire summer period of 1994 – somehow completely failed to notice the first 7cms of his hepatoma growth? As damning an indictment of both doctors as ever there could be.

Regarding Dr Whiteman's treatment of "*allegation 8*", it doesn't seem to have occurred to her – and she was not alone, to be fair – that she casually referred to the "*potentially risky invasive procedure*" of a liver biopsy in a haemophiliac as being reason to withhold such treatment, whilst all the time knowing that both Drs Hay and Gilmore then later supported last ditch plans for William to have a liver transplant, surely a riskier procedure by many hundreds of factors of magnitude. In any case, her assertions were shot with inconsistencies and skewed details. It was deeply regrettable, though, that she evidently held so much sway. For clearly her particular phraseologies and conclusions then largely set the tone for what followed at the GMC concerning William's case. Thereafter, much of the documentation was simply a copy-and-paste exercise in re-presenting her flawed conclusions.

It is clear to us now that Ms Longstaff, in July 2004, had effectively ensured that the GMC screeners followed Dr Davies' then seven-year-old, erroneous verdict to the letter and that Ms Whiteman then became the first GMC official, just one month later, to duly comply and so regurgitate his deeply flawed submissions, thus effectively ensuring that the injustice we were subjected to in 1997 was then served back to us, cold, in 2004.

6.12

We note that the document (WITN3365023_001-20 through 23) – which can be adequately described here as "*Section 10; Conduct*" – as signed by an anonymous "*lay screener*" just one day after Ms Whiteman had signed her own screening form as far as "*Section 9*", (despite the sheer complexities of William's case and the "*voluminous*" medical records) was the second of the two seminal materials, (following Ms Whiteman's), that essentially set-in-stone the various phraseologies, skewed realities and revised narratives that ultimately formed the basis of the final opinion served by the GMC to us in early 2005 as a rejection of our case. Mr Cox-Brown's former viewpoints, and indeed Dr Keighley's, seemed to completely disappear.

Regarding the lay screener's treatment of "*allegation 1*", s/he at least made it clear from the outset that Dr Davies' verdict from 1997 would be the dominant voice regarding the future of what, clearly, was our already dead-in-the-water case. It is intriguing, though, that although we never held either of Dr Little's or Dr Machin's reports in high regard – far from it; albeit there were more nuances in both, when contrasted with Dr Davies' flawed submission – neither of those two other "*expert*" submissions were ever quoted by GMC officials. Why was it always Dr Davies' report that was regarded as the go-to source, we wonder?

Regarding the lay screener's bogus description of the gap between the availability in "*late 1991*" of a test for Hepatitis C (September, in fact) and Dr Hay's "*testing*" of William for such in "*March 1992*" (we wonder, then, how he was somehow informed in January 1992 that he had Hepatitis C, as confirmed in the medical records, if he wasn't tested for several weeks thereafter?), we know well the sleight-of-data that s/he was trying to deceptively convey. In any case, it seems that it was being argued that it was somehow acceptable to delay such a test even for some six months, despite UK medics having apparently clamoured for the arrival of an HCV test for years and that, accordingly, they therefore should have all been on the starting-blocks in readiness to approach their most compromised patients – like William – on day one of availability in September 1991, especially knowing that major surgery was imminent. Once again, we would assert that it simply never even occurred to Dr Hay, at any point between September and December 1991, to test William and it was only the complications from his knee surgery that finally prompted him.

We would ask, then, if it was deemed acceptable to not test a known Hepatitis A, B, and Non-A, Non-B infected patient for chronic Hepatitis C for the first six months of a long-awaited test's availability, then at what point would a delay have been deemed unacceptable? Seven months? Eight? What if William had never had his knee operation, and therefore not suffered the complications that then exposed his true hepatic status? When would Dr Hay have finally bothered to test him for Hepatitis C, and what would have been the prompt for him to do so?

We can see now that it was the lay screener who also set in place the canard – lifted from Dr Davies' report – that there were no "*contra-indications*" prior to William's knee surgery. For this was another regular sophism used to discredit our allegations, despite it being clear that our substantive point had always been that it was only the *aftermath* of William's unsuccessful surgery that proved Dr Hay's inadequate supervision of his patient's hepatic health in the long years *beforehand;* our point – in that regard – wasn't that he submitted him, *per se*, for surgery (twice, including the cancelled procedure of August 1991). In any case, Dr Hay's own documented assertion was that he wouldn't have done so had he known of the "*severity*" of William's disease. It has always been plain, from that last admission alone, that Dr Hay had not been adequately monitoring William prior to December 1981. Yet the precise nuance of our very first allegation, using the signal episode of William's knee surgery - indisputably the key medical event triggering the beginning of his long demise and death – has always been twisted to work against our contentions, by a succession of medics and lay screeners. We wonder why.

Regarding the lay-screener's treatment of "*allegation 4*", we ask as to what basis s/he had for asserting that William was "*clearly aware*" that he was being monitored for "*liver disease*"? Was there a document to this effect in circulation that we have never seen sight of? Perhaps signed by William? We wonder, then, that if he so "*clearly*" knew that he was being so monitored for "*liver disease*", as to why it then came as such a shock to both him and, indeed, Dr Hay, that he had already developed cirrhosis of the liver by January 1992? Would it not have been more reasonable for the lay screener to have inferred that William, knowing that he had been twice cleared for major surgery in 1991 (August and December), and had also undergone a significant procedure in late 1990, could have justifiably thought himself to be hepatically healthy in December 1991, even despite his multiple infections from 1968-1981?

Regarding the lay-screener's treatment of "*allegation 5*", we hold it be a gross distortion of reality. Any objective reading of the events and sequences that unfolded during the late spring and summer of 1994 would reach the same conclusion. We wonder why the screener did not do so.

Regarding the lay-screener's treatment of "*allegation 6*", firstly, we regret to say, once again, that this was an outright lie. The referral of William to Dr Gilmore – by Dr Hartley, not Dr Hay, but once again this fact was omitted – was categorically not made "*at the point when the cancer was diagnosed*". How was it possible that both Dr Whiteman and then the lay-screener, just 24 hours apart, reached the same erroneous conclusion which would have been an impossible verdict to settle on from even a cursory reading of the "voluminous" medical records (e.g. Professor Bassendine's letter to Dr Gilmore in August 1994, to state just one damning exhibit)? We trust that the IBI will be able to at least attempt to uncover that matter. Secondly, it was simply not possible for anyone to read William's medical records – even from the point of his first varices episode in April 1992 – and conclude that "*there* [was] *nothing to suggest that there were earlier indications which would have made such a referral* [to Dr Gilmore] *imperative, or that it would have altered the course of events*". The screener, then, evidently didn't believe that three episodes of variceal haemorrhaging, plus all of the other complexities that William suffered from January 1992 onwards, merited him being referred earlier to Dr Gilmore (who himself admitted that he got him "*too late*") nor that, had such happened, then prospects for an earlier liver transplant, say circa summer 1993 at the very latest, would have changed the course of events?

We will say flat-out now, after reading both Dr Whiteman's and the lay-screener's verdicts, that they seemed to be jointly determined to distort every possible angle in order to prevent our case against Dr Hay going forward. That much is plainly obvious. The evidence is there to be seen that such must have been the case, for they had both had to work incredibly hard to so repeatedly and determinedly avoid the obvious evidence that was set before them. Such pattern-like dissonance, from two separate individuals, simply doesn't happen by accident. We wonder why it was the case, then, and we trust that the IBI will investigate.

Finally, regarding the lay-screener's regurgitation of Dr Davies' assertion that it was not "*accepted practice to screen patients with cirrhosis for liver cancer*", we just simply ask the following: did it never occur to any of the authors who either originated that hideous assertion, or then blithely repeated it, as to how stupid that sequence of words really sounded? Not to mention how crass. Who, then, would ever have been screened for liver cancer, and on what medical bases?

6.13

We don't believe that there is any need for to provide a structured response to any of the further documents sent to us by the IBI last week. For it is clear that, in the wake of both Ms Whiteman's and the lay-screener's verdicts, all further GMC communications beyond August 2004 were rehashes of their erroneous conclusions. Indeed we wonder why it then took another nine months for the inevitable to be communicated to us by Mr GRO-D. Perhaps a feigned delay, for cosmetic purposes only to give the impression of an ongoing investigation? And, sad to say, it was evident that even Mr Cox-Brown – who had once seemed to correctly grasp the validity of our case – was eventually convinced by such wilful distortions, certainly judging by the "*Case Examiner Referral Form*" (WITN3365023_001-2 thro 7), dated 14th February, 2005, that he signed. Astonishingly, he blithely seemed to go through the copy-and-paste motions to such a disinterest degree that he inexplicably and insultingly recorded that the events in question took place in "*1990*".

It seems that the demise of our case followed a three-fold pathway: i) the distortions first set in place by Dr Davies in 1997; ii) the aggressiveness of Ms Longstaff's communications in ensuring that the report(s) from seven years earlier was/were introduced into the investigation and became definitive; and iii) then the compounded distortions – and we state outright lies concerning two particular aspects – peddled by both Dr Whiteman and then the anonymous lay screener (tellingly just one day later) concerning their creatively deceptive presentations of Dr Davies' original verdict.

We never stood a chance. We had always feared that such would be the case. For a brief while, in spring 2004, we dared to believe the opposite. We now know, in 2020, that our initial instincts were correct all along.

We maintain, therefore, even more forcefully than we did prior to receiving the documents submitted to us by the IBI last week, that every point we made regarding the GMC in part one of our witness statement submitted last summer stands. Especially the following, as stated at paragraph 267: "[…]*we now have no hesitation in listing the GMC alongside pharmaceutical companies, international governments, the UK Department of Health, a succession of senior ministers, and many medics as being part of the wider veil that either purposefully covered* [up] *the CBS these last several decades, or at least minimised its devastating realities.*"

We had cited Mr GRO-D, being the signatory of the GMC's final decision to us in March 2005, as being the symbolic front for the compounded injustice that was served against us in 2004/05. We can now see, after the IBI's submission of key documents to us, that he was among several GMC officials whom we should also hold culpable, namely: Mr Cox-Brown; Dr Whiteman; and the anonymous "*lay screener*".

7. Concerning our future evidence, and particularly Part Two (1994-present) of our Witness Statement; personal statement from Anne Elizabeth Anakin and Gregory William Murphy

We write the following requesting absolute confidentiality about its contents:

GRO-C

GRO-C

GRO-C

GRO-C

ANNE ELIZABETH ANAKIN; DOB: GRO-C

GREGORY WILLIAM MURPHY; DOB: GRO-C

* Gregory’s contact details: GRO-C Liverpool, GRO-C

* Tel: GRO-C

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[redacted]

From: Contaminated Blood [redacted]
Subject: Questions for Christine Lee
Date: 9 October 2020 at 14[redacted]3[redacted]3
To: gregmurph [redacted]

Dear Greg,

On 20 and 21 October 2020 the Inquiry will be hearing live evidence from Professor Christine Lee. We are writing to send you a copy of her statement and to invite any questions you may have for her.

The statement is available here: https://leighday.sharefile.com/d-s22124cc9f6940e88

Please ensure you provide your questions by **10am on Tuesday 13th October 2020** to ensure we are able to send your questions to the Inquiry seven days in advance of Prof Lee giving evidence, as required by the Inquiry team. We apologise for the short turnaround time for this witness, however, this statement was only disclosed by the Inquiry yesterday.

Summary

Professor Christine Lee was a Senior Registrar at the Royal Free Hospital's Haemophilia Centre from 1982 to 1984, and became a Consultant and the Director of the Haemophilia Centre in 1991 after the medical retirement of Professor Kernoff. In the 1980s, Prof Lee worked closely with Prof Kernoff on research concerning the infection of haemophiliacs with hepatitis. Prof Lee's statement to the Inquiry

[redacted] [redacted]

discusses her involvement with various research studies, as well as her knowledge of the risks of contracting HIV and hepatitis from blood products and the information provided about this to patients at the Royal Free Haemophilia Centre.

While under the direction of Prof Kernoff, Prof Lee's statement notes she was not responsible for decision-making about patients' treatment, however she notes that there was a policy for children to receive only NHS concentrate and for mild haemophiliacs only DDAVP, while severe and moderate haemophiliac adults received a mixture of NHS and commercial concentrate. The statement also discusses observational studies she was involved in which identified the rate at which patients treated with factor products contracted hepatitis.

Questions

Having considered Prof Lee's statement, we anticipate asking questions in the following areas:

- Policies in relation to selection of patients for different types of blood products;

- Patient consent for and ethical approval of observational studies in the 1980s (when NHS products were thought to be safer than commercial products);

- The developing knowledge of the link between blood products and HIV transmission, in terms of (i) when commercial factor concentrates stopped being used and (ii) whether and when patients were informed of this risk;

- Patient choice around factor products used.

[redacted]

Please let us know by 10am on Tuesday 13th October whether you have any questions for Prof Lee that you would like us to put to the Inquiry on your behalf.

With best wishes,

The Leigh Day team

Zoe Johannes, Assistant Solicitor to Emma Jones

[redacted]

Leigh Day

[redacted]

[redacted]

From: Contaminated Blood [redacted]
Subject: Questions for Professor Edward Tuddenham
Date: 13 October 2020 at 7[redacted]1[redacted]8
To: Maureen [redacted]

Maureen

On 22 October 2020 the Inquiry will be hearing live evidence from Professor Edward Tuddenham. We are writing to send you a copy of his statement and to invite any questions you may have for him.

The statement is available here:

https://leighday.sharefile.com/d-s487571a071a445ba

Please ensure you provide your questions by **10am on Thursday 15th October 2020** to ensure we are able to send your questions to the Inquiry seven days in advance of Prof Lee giving evidence, as required by the Inquiry team. We apologise for the short turnaround time for this witness, however, this statement was again only disclosed by the Inquiry yesterday.

Summary

Professor Edward Tuddenham was a Lecturer in Haematology at the Welsh School of Medicine from 1972 to 1975, and then served as co-Director of the Royal Free

[redacted]

Hospital Haemophilia Centre from 1978 to 1986 alongside Professor Kernoff. Prof Tuddenham did not have many clinical responsibilities after 1979, when he began to devote more time to his research on the purification of Factor VIII. Prof Tuddenham's statement to the Inquiry discusses his awareness of the research being conducted by Professors Lee and Kernoff, his knowledge of the risk of transmission of hepatitis and HIV during various periods, and his opinions on self-sufficiency in blood products.

Questions

Having considered Prof Tuddenham's statement, we anticipate asking questions in the following areas:

- Policies in relation to selection of patients for different types of blood products;
- Concerns about the failure to achieve self-sufficiency in blood products;
- Patient consent for and ethical approval of observational studies in the 1980s (when NHS products were thought to be safer than commercial products);
- The developing knowledge of the link between blood products and HIV/hepatitis transmission, in terms of when commercial factor concentrates stopped being used

Please let us know by 10am on Thursday 15th October whether you have any questions for Prof Tuddenham that you would like us to put to the Inquiry on your behalf.

h [redacted]

[redacted]

From: Contaminated Blood [redacted]
Subject: Professor GRO-D
Date: 20 October 2020 at 7[redacted]1[redacted]4
To: Maureen g[redacted]

Maureen

On 2 and 3 November the Inquiry will be hearing live evidence from Professor GRO-D We are writing to send you a copy of his statement and to invite any questions you may have for him.

Professor GRO-D has not included the questions he was asked to answer in his statement, so we have also included a copy of the Rule 9 document with the questions on it. Both the statement and Rule 9 letter are available here:

https://leighday.sharefile.com/d-sc1f09d9199b45bda

Please ensure you provide your questions by **10am on Friday 23rd October 2020** to ensure we are able to send your questions to the Inquiry seven days in advance of Prof GRO-D giving evidence, as required by the Inquiry team.

Summary

Professor GRO-D was a Consultant Haematologist at the Royal Hallamshire Hospital and Director of Sheffield Haemophilia Centre from 1974 to

[redacted] [redacted]

2000. He was also the Director of the WHO Collaborating Centre for the Diagnosis and Comprehensive Care of Patients with Bleeding and Clotting Disorders from 1994 to 2000. Whilst at the Sheffield Haemophilia Centre, he was responsible for decision making about which blood products to purchase for patient use. His statement discusses his knowledge of the risk of infection during the 1970s and 1980s, the Sheffield Haemophilia Centre's policies for prescribing blood products for different groups of patients, and paid research he participated in involving the use of commercial concentrates.

Questions

Having considered Prof GRO-D s statement, we anticipate asking questions in the following areas:

- Policies in relation to selection of patients for different types of blood products;
- Policies in relation to communication with patients about the risk of infection and monitoring them for infections;
- Decision making by Haemophilia Reference Centre Directors and the UKHCDO;
- Patient consent and selection for research studies in the 1980s, and the results of these studies;
- Interaction with pharmaceutical companies.

[redacted]

Please let us know by 10am on Friday 23rd October whether you have any questions for Prof GRO-D that you would like us to put to the Inquiry on your behalf.

With best wishes,

The Leigh Day team

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[redacted]

From: Contaminated Blood [redacted]
Subject: Questions for Professor Franklin, Dr GRO-D and Professor Parapia for w/c 26 October 2020
Date: 14 October 2020 at 14[redacted]3[redacted]6
To: Maureen [redacted]

Maureen

On 27th, 28th and 29th October 2020 the Inquiry will be hearing live evidence from Professor Ian Franklin, Dr GRO-D and Professor Liakat Parapia. We are writing to send you a copy of their statements and to invite any questions you may have for them.

Their statements are available here:

https://leighday.sharefile.com/d-s9d31322e9b146968

Please ensure you provide your questions by **10am on Monday 19th October 2020** to ensure we are able to send your questions to the Inquiry seven days in advance of these clinicians giving evidence, as required by the Inquiry team.

Summary

Professor Franklin (27th and 28th October)

[redacted]

Professor Ian Franklin was a Consultant Haematologist and Co-Director of the Haemophilia Centre at Queen Elizabeth Hospital in Birmingham from 1983 to 1992. Subsequently he worked as a Consultant Haematologist at Glasgow Royal Infirmary from 1992 to 1996, and then as the National Medical and Scientific Director of the Scottish Blood Transfusion Service from 1996 to 2010. Professor Franklin's statement to the Inquiry discusses the development of his knowledge of the risk of hepatitis and HIV from blood products, communication with patients about these risks, the policies of the UKHCDO in relation to the usage of particular products, and risks to patients other than haemophiliacs (i.e. recipients of bone marrow transplants and Anti-D injections).

Dr GRO-D (28th October)

Dr GRO-D was a registrar in Haematology at the Northern General Hospital in Sheffield from November 1984 to October 1986. He was then lecturer in haematology at the Royal Hallamshire Hospital, Sheffield, from 1986 to 1988 where he ran the weekly Haemophilia Clinic, though his care of inpatients was limited to when he was on call. From 1988 to 1992 he was senior registrar at the Royal Liverpool Hospital, with Dr Charles Hay as director of the Haemophilia Clinic. Dr GRO-D had little input into clinical care decisions as the service was consultant led. From 1992 to 2016 Dr GRO-D was consultant haematologist and director of the Haemophilia Service at Queen Elizabeth Hospital, Birmingham. One of his roles as consultant was management of the factor concentrate budget and making decisions as to choice and procurement of factor concentrates. His statement notes that Dr GRO-D became aware in the early 1980s that non A non B hepatitis affected most haemophilia patients who had received non virally inactivated factor concentrates, and that this was caused by hepatitis C (when this was identified in the late 1980s).

-

Professor Parapia (29th October)

Professor Liakat Parapia was a Consultant Haematologist and Director of Bradford Haemophilia Centre from 1982 to 2009. During this time he was responsible for decision-making about which blood products to give patients, based on UKHCDO guidelines. His statement discusses decision-making about the types of factor products given to patients, developing knowledge of the risk of infection from blood products, steps taken to reduce this risk and communication with patients.

Questions

Having considered their statements, we anticipate asking questions in the following areas:

- Policies in relation to selection of patients for different types of blood products;
- Concerns about the failure to achieve self-sufficiency in blood products;
- Interaction with pharmaceutical companies;
- The developing knowledge of the link between blood products and HIV/hepatitis transmission in terms of when commercial factor concentrates stopped being used;
- Communication with patients, including communication of risks of infection, testing for infections (including storing serum for testing without patient consent), and follow-up/monitoring.

Please let us know by 10am on Monday 19th October whether you have any questions for any of these clinicians which you would like us to put to the Inquiry on your behalf.

[redacted]

From: Contaminated Blood [redacted]
Subject: Summary of 20 to 22 October Hearings
Date: 26 October 2020 at 10[redacted]0[redacted]8
To: Maureen [redacted]

Maureen

Last week the Inquiry heard from clinicians at the Royal Free Hospital, Professor Christine Lee and Professor Edward Tuddenham.

The link to the transcripts and videos of the evidence can be found here: https://www.infectedbloodinquiry.org.uk/evidence

Our team did not consider Professor Christine Lee's evidence to be particularly helpful, and what she said in oral evidence did not go much beyond what was already set out in her written statement. She frequently told the Inquiry that she either could not remember the events in question, or that she was unable to comment or give any opinion as she was not present at the relevant time. Professor Lee acknowledged that the Royal Free Hospital stored the serum of individuals for future research and that patients were tested for HIV without their knowledge or consent. Similarly, later on, patients were advised there was a test for HCV at the same time they were told their test result, having again been tested without prior consent. Professor Lee also acknowledged that it was not the practice of the hospital to discuss treatment choice (i.e. the type of product, such as whether it was cryoprecipitate or commercial concentrate) with patients as this was a matter for the doctor.

Professor Tuddenham's evidence to the Inquiry was much more helpful. His

[redacted] [redacted]

[redacted]

evidence was wide ranging and made the following key points which we consider will be very helpful to the Inquiry in making its recommendations in due course:

- Professor Tuddenham was unaware of the donor risks in the USA, assuming they had similar standards to the UK at the time;
- With hindsight, the risks of large donor pools were not sufficiently appreciated;
- By 1978, he was aware, as was Dr Kernoff (also at the Royal Free) that non A, non B hepatitis (NANBH) was a clinically significant condition with potentially serious longer term consequences and that patients should have been told of these risks, also acknowledging that in the early 1980s the Royal Free did not change their treatment policy in response to the emerging risk of NANBH;
- By July 1982, he was aware of the association between haemophiliacs receiving concentrates and AIDS, and that patients should have been told of these risks and had a choice in terms of what treatment they received, also noting that he was unaware of the Galbraith 1983 paper recommending withdrawal of all US blood products in the UK – he felt that if this paper has had wider exposure then it may have had some effect. He accepted that the Royal Free only changed its policy on its approach to treatment in December 1984;
- The UK Haemophilia Centre Doctors' Organisation response and guidelines in relation to AIDS was, he thought, when viewed with hindsight, very gradual and vague;
- He acknowledged that the Royal Free ought to have considered offering other treatments, such as cryoprecipitate, in the months when there was a phased introduction of heat treated products at the hospital (which would have potentially protected patients from continuing to be treated with unsafe non heat treated products during this transition);
- He acknowledged that the industry impetus to improve factor concentrates came rather slowly, as the pharmaceutical industry had a product which they could sell, and did. He believes there was a commercial incentive to sell factor product which overwhelmed safety issues;
- Professor Tuddenham maintained his view that there might only have been half the number of HIV infected patients if self-sufficiency in blood products had been achieved in 1976.

Questions for Professor Hay

[redacted]

On 4 and 5 November 2020 the Inquiry will be hearing live evidence from Professor Charles Hay. We are writing to send you a copy of his statement and to invite any questions you may have for him.

The statement is available here:

https://leighday.sharefile.com/d-s95551bcbbbe46afb

Please ensure you provide your questions by **10am on Wednesday 28th October 2020** to ensure we are able to send your questions to the Inquiry seven days in advance of Prof Hay giving evidence, as required by the Inquiry team.

Summary

Professor Charles Hay is a Consultant Haematologist and Director of the Haemophilia Centre at the Manchester Royal Infirmary, a position that he has held since 1994. Before moving to Manchester Royal Infirmary, he was director of the Mersey Region Haemophilia Centre between May 1987 and November 1994 during which time he also provided a Haematology Service for Liverpool Women's Hospital. He had responsibility for the Haematology inpatients and conducted weekly outpatient clinics. Between 1982-1987 he was a rotating Senior Registrar in Haematology and Hon. Clinical Tutor at Sheffield University Hospitals during which time he was given day to day responsibility for the running of the Sheffield Haemophilia Centre under the direct supervision of Professor GRO-D From 2005 to 2011 he was chair of the UKHCDO alongside which he also sat on a large number of committees and associations.

The statement from Professor Hay goes into detail about his knowledge or, and response to risk. By the time Professor Hay took up his post in Sheffield, Professor GRO-D's Lancet Paper had been published for 5 years. He was aware therefore of

NANB hepatitis and the belief that it was transmitted by blood or blood products. He states that in 1983 there was no different in the risk of NANB hepatitis between commercial and BPL concentrates but that the relative risk of transmission of the virus responsible for AIDS was unknown until 1984. In response to the risk, Professor Hay response was that the risk was addressed by using DDAVP where possible, avoiding switching brands (again where possible) and adopting the use of heat treated products at the earliest opportunity.

On consent generally, Professor Hay's statement sets out when he would and would not have sought consent a range of different tests and procedures. Specifically on the issue of consent for testing to be used in trials, and in responding to whether patients were aware that they were part of the 1985 study "Progressive Liver Disease in Haemophilia: An Understated Problem?", Professor Hay states *that "This was an observational study. Either I or Dr Trigger took consent from the patients for the liver biopsy as one would for any invasive diagnostic procedure."*

The statement, in response to direct questions in the accompanying Rule 9 letter, provides information about Professor Hay's involvement with pharmaceutical companies. He answers "no" to the question of whether he ever received any financial incentives from pharmaceutical companies to use certain blood products but he has acted as an invited speaker and has attended advisory committees for a number of companies.

Professor Hay's statement explains that he lead and directed the National HCV Lookback Exercise on behalf of the DH between 2010-2013, which was a recommendation adopted in light of the Archer Inquiry. Finally, his statement concludes with some reflections on other issues, including comments he has made in relation to "patient activists" and "campaigners" in the past.

Questions

Having considered Prof Hay's statement, we anticipate asking questions in the following areas:

- Policies in relation to selection of patients for different types of blood products;
- Communication with patients about their treatment and risk of infection;
- Patient consent for the storage of blood samples and participation in research;
- The developing knowledge of the link between blood products and HIV/hepatitis transmission

Please let us know by 10am on Wednesday 28th October whether you have any questions for Prof Hay that you would like us to put to the Inquiry on your behalf.

With best wishes,

The Leigh Day team

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[redacted]

From: Contaminated Blood [redacted]
Subject: Questions for Dr Al-Ismail & Dr Giangrande
Date: 4 November 2020 at 17[redacted]2[redacted]1
To: 'Maureen' g[redacted]

Dear Maureen

Sir Brian has announced that the hearings will continue as timetabled throughout the national lockdown, however there will be some changes. Only Sir Brian and Counsel to the Inquiry Jenni Richards will be in the hearing room, all witnesses will be giving evidence remotely. Members of the public and legal representatives will not be permitted to attend in person. Sir Brian's full comments can be found here

The Leigh Day team will continue to follow the evidence closely, but will do so remotely.

The Inquiry will be hosting a meeting online after each week of hearings for people who would like to talk to others about their experience of watching the hearings. If you would like to find out more about these meetings please contact the **Inquiry's engagement team** on contact@i[redacted] or 0808 [redacted]

Hearings week of 16 November

During the week beginning 16 November the Inquiry will hear from the following witnesses:

- Dr Saad Al-Ismail (Swansea Hemophilia Centre) – Tues 17th /Weds 18th

[redacted] [redacted]

- Dr Vivian Mitchell (Leicestershire Hemophilia Centre) – Weds 18th / Thurs 19th
- Dr Paul Giangrande (Oxford Hemophilia Centre) – Thurs 19th /Fri 20th

The statements of Dr Al-Ismail and Dr Giangrande can be downloaded from this link:

https://leighday.sharefile.com/d-sea077c38bad4f33a

The Inquiry has uploaded the statement for Dr Vivien Mitchell this afternoon. We have not yet had the opportunity to review it but will send this statement and a short summary as soon as we are in a position to do so. In the meantime, we invite you to send us suggested questions for Dr Al-Ismail and Dr Giangrande. Please ensure that you provide these questions by **midday on Monday 9 November 2020.** As always we will send all of your questions to the Inquiry team however there is no guarantee that all questions will be asked.

Dr Al-Ismail summary & proposed lines of questioning

Dr Al-Ismail started working at Swansea Haemophilia Centre (SHC) as a consultant haematologist in 1982. He was made director of the Centre in 1985 and continued in this role, with a short hiatus, until his retirement in February 2018. He was a member of UKHCDO but did not participate in any of its working parties.

Although SHC was considered a haemophilia centre in its own right, it operated under the direction of the Cardiff Haemophilia Centre led by Professor Bloom until 1992. Dr Al-Ismail's main specialism was haemato-oncology; most of his working life was spent in general haematology rather than being primarily focussed on the treatment of patients with bleeding disorders.

In his statement he describes how the policies and procedures at SHC in relation to the choice of blood products to give to patients were shaped by the guidance of Professor Bloom.

Dr Al-Ismail explains how, over time, clinical teams have been set up to treat HIV and HCV in Swansea. In around 2006 a chronic viral hepatitis service was established. In 2014 a part time psychologist and part time physiotherapists were appointed to work with SHC patients.

Having considered Dr Al-Ismail's statement, we anticipate asking questions in the following areas:

- Further explanation of the relationship between SHC and Cardiff Haemophilia Centre and how this worked in practice
- Did he have the authority to act against any recommendations made by Professor Bloom?
- Further explanation of the development of his knowledge of risk of HIV and/or HCV infections and how this impacted his advice to patients
- Details of the benefit of linked services with HIV specialists and hepatologists with specific interest in viral hepatitis
- Details of the benefit of a psychologist working with patients with bleeding disorders

Dr Giangrande summary & proposed lines of questioning

Dr Giangrande took over directorship of the Oxford Haemophilia Centre (OHC) in April 1991. He held this post until he retired at the end of May 2015. He was a member of UKHCDO during that time but never held a senior elected position.

He has had no clinical experience of using cryoprecipitate.

His statement indicates that he was a proponent of recombinant products from quite early on. He was in favour of switching patients to such products because of the risks associated with other products. He wrote in a 2003 journal "*The reality is that it is simply the increased cost of recombinant concentrates compared to conventional plasma products, rather than rational scientific arguments, which is the principal obstacle to their wider use*".

However, he was not responsible for deciding which products should be purchased at OHC.

In relation to vCJD he is of the view that patients should have been told of the risks at an earlier date and alternative treatments considered. In 1998 the New Scientist Journal featured an article about Britain's plan to filter white cells from all donated blood at a cost of 70 million a year to minimise the risk of vCJD. This article mentions that Paul Giangrande, agreed that the government had been slow to act**, "*This decision should have been taken ages ago. If you look at the HIV litigation that's taking place in the US and elsewhere, months mattered*". (our emphasis)**

Having considered Dr Giangrande's statement, we anticipate asking questions in the following areas:

- What steps did he take to inform patients/switch products once he was aware of the risks of vCJD?
- Who was involved in the Trust's Procurement Department and the policies relating to the purchase of products at OHC?
- Why he didn't push more for the use of recombinant products (RP)? Why does he think wide spread use was resisted? In his opinion why was there a delay in the widespread use of RP
- Explore the use of alternative treatments such as DDAVP particularly for mild haemophiliacs

- Patient consent for the retention of samples
- Why patients were not asked for their consent for their data to be entered and stored on the UKHCDO database
- Interaction with pharmaceutical companies.
- Charging patients a fee for assistance with completing application forms for financial assistance.

We look forward to receiving any comments or questions by **midday on Monday 9 November 2020.**

With best wishes,

The Leigh Day team

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From: Contaminated Blood [redacted]
Subject: Summary of Last Week's Hearings & Questions for Dr Mitchell
Date: 9 November 2020 at 17[redacted]5[redacted]8
To: Maureen [redacted]

Dear Maureen

Last week the Inquiry heard from Professor GRO-D, former Director of the Sheffield Haemophilia Centre, and Professor Charles Hay, Director of the Manchester Haemophilia Centre.

The link to the transcripts and videos of the evidence can be found here: https://www.infectedbloodinquiry.org.uk/evidence

Our team did not consider Professor GRO-D's evidence to be particularly helpful, and what he said in oral evidence did not go much beyond what was already set out in his written statement. It was our impression that he was simply unable to remember much of what happened during his time in practice, and it would be most helpful to the Inquiry to understand his position as he set it out in his evidence to the Lindsay Inquiry in 2001.

Professor Charles Hay's evidence to the Inquiry was more helpful. His evidence was wide ranging and made the following key points which we consider will be very helpful to the Inquiry in making its recommendations in due course:

- Counsel for the Inquiry opened her questions with an overview of Prof Hay's roles and responsibilities during his time in Sheffield, Liverpool and Manchester. On the subject of use and selection of products while at Sheffield, Prof Hay explained that he inherited Professor GRO-Ds policies of batch dedication for patients and not putting "all of your eggs in one basket" in terms of commercial products. He subsequently adopted both policies in Liverpool and Manchester.

- Prof Hay was questioned about what information he would have explained to his patients about NANB when it first started to emerge and he said that he would have reassured patients that there was a high risk of transmission but that the consensus at the time was that it was benign and non-progressive. Counsel for the inquiry spent some questioning Prof Hay on where the factual basis for that consensus was in the literature and at times he was equivocal in his answers. The line of questioning pursued by Counsel for the inquiry revealed that the consensus may have changed over time but Prof Hay explained that even if that was the case, the policy of the Centre in Sheffield was always broadly aligned with the guidance published by UKHCDO.
- Professor Hay then went on to explain his response to the developing knowledge of the risk of AIDS in the early 1980s. He said that although he was initially unclear as to the level of risk, his approach was to use DDAVP were possible.
- Prof Hay was questioned about why he did not consider switching patients back to cryoprecipitate in about 1983-84 for a short period until heat treatment and an HIV test were developed, to reduce the risk of HIV transmission in the meantime. He raised the issue that haemophiliacs had a lower life expectancy before factor concentrates were used, and that moving back to cryoprecipitate would be a risk to patients' lives. Prof Hay was then shown evidence from Dr Rizza and Dr Biggs' research which demonstrated that the death rate from intracranial bleeding did not decrease significantly with the move from cryoprecipitate to the wide use of factor concentrates.
- In the afternoon, Counsel for the inquiry asked Prof Hay questions about the process of testing patients for HIV / Hepatitis C. In particular, Prof Hay was asked about the manner in which express consent was sought, or not. Prof Hay explained that a lot of patients were tested for HIV on the basis of stored samples but that he would discuss the test in advance. When testing for Hepatitis became available, Prof Hay was Director of the Haemophilia Centre in Manchester and he said that patients were tested by coming into the clinic. He said that it was mentioned to them as an additional test which would be discussed in advance.
- Prof Hay was Chair of UKHCDO from 2005 to 2011 and a member since 1987. He noted that UKHCDO has historically (and still does) receive funding from pharmaceutical companies in the form of sponsorship of their Annual General Meetings, as well as funding for particular research projects. In return for their sponsorship, these companies are able to attend the meetings and set up a stall in the exhibition area. He was not able to comment on measures taken to prevent this sponsorship from influencing Directors' decisions about which products to use, but noted that favouring one product too much over another might leave one open to

accusations of bias.

- Prof Hay noted that records of the batch numbers and products patients had received would not necessarily be in their clinical notes, but would be contained in a separate ledger his Centre kept containing batch numbers and treatment administered to all patients. If patients requested their hospital records, they might not be given information from this ledger as it contained other patients' data, and may therefore not receive any information about the products they received.
- Prof Hay gave conflicting evidence about obtaining consent from patients to store blood samples for future testing. He said that he did obtain consent from patients to store samples for 'general research', but that after this initial consent he did not contact them in future if he planned to conduct a test on the samples.
- When recombinant products first became available, he experienced difficulty obtaining funding from the Department of Health to purchase it, as it was more expensive than plasma derived products. This resulted in a period of about three years during which it was introduced on a phased basis. During this time he and other directors had to make decisions about which patients should be prioritised for the treatment, and some patients (including children) who had been using recombinant on a trial basis were then switched back to plasma derived products. When the Department of Health did agree to fund recombinant treatment for all patients, they still did not accept that a key reason for doing so would be to prevent the risk of future viral transmission.

<u>Hearings week of 16 November – Proposed Lines of Questioning for Dr Mitchell</u>

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Dr Vivien Mitchell was Consultant Haematologist at University of Hospitals Leicester between 1979 and November 2003. He was responsible for developing a service in haemostasis and thrombosis including haemophilia.

He had been a Senior Registrar at Sheffield Royal infirmary between 1975 and 1978 and was involved (alongside Professor GRO-D) in the Sheffield study as published in medical journal the Lancet in 1978. This study examined chronic liver disease in haemophiliacs and the possible link with factor concentrates. Dr Mitchell was convinced that for some patients treated with factor concentrate, liver disease could be progressive.

[redacted]

As a result, Dr Mitchell formulated a treatment policy for his patients in Leicester which restricted the use of large donor pool factor VIII concentrates. DDAVP and antifibrinolytic therapy were used wherever possible; patients with Von Willebrand's disease and mild to moderate haemophilia were treated with cryoprecipitate if required. Children with severe Haemophilia A were treated with cryoprecipitate until they went on to home treatment. Exposure of adult patients with severe haemophilia A was limited by purchasing as much as possible of a batch from a single commercial supplier. Dr Mitchell believes this policy helped to reduce the numbers of patients infected with HIV at the Leicester Haemophilia Centre.

-

Having considered Dr Mitchell's statement, we anticipate proposing the following lines of questioning:

- The extent to which he informed his patients of the risk of infection from factor concentrates
- The response of Haemophilia consultants in other localities to his treatment policy
- The practicalities of treating patients with cryoprecipitate
- His relationship with pharmaceutical companies

Dr Mitchell's statement can be downloaded here: https://leighday.sharefile.com/d-sb992d253f688431

Please note that parts of the statement are difficult to make sense of without knowing the question asked. The Inquiry has confirmed that the questions will be disclosed however these have not yet been received. Due to the tight timeframe we wanted to send you the summary today so that you would have the opportunity to feed into the proposed lines of questioning.

Please provide your questions by **4pm on Wednesday 11 November 2020** so that we may forward them to the Inquiry seven days in advance of Dr Mitchell's evidence in accordance with the deadline set by the Inquiry team. We apologise for the short turnaround time for this witness, this is due to a

[redacted]

[redacted]

delay in the statement being disclosed to us. Any questions received after Wednesday will still be considered by the Leigh Day team and may be put to the Inquiry.

With best wishes,

The Leigh Day team

Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB

[redacted]

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[redacted]

<u>Communication to the Infected Blood Inquiry (sent jointly to Leigh Day solicitors) by Mrs A. Anakin and Mr G. Murphy, regarding our future participation, and the events that have unfolded since August 2020.</u>

<u>November 15th, 2020</u>

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Preamble

We wish to communicate our feelings, convictions and stance concerning our intention to curtail future *proactivity* with the Infected Blood Inquiry (IBI). This does not preclude us responding *reactively*, should that ever be required. We await advice in that regard.

We feel that we have been given little choice – considering the unjust circumstances prevalent since 13th August, 2020 – but to act with our self-protection foremost in mind.

We realise that we are likely incurring the IBI's further pronounced dissatisfaction by submitting this statement jointly to the Engagement Team, and our legal representatives, Leigh Day. However, given that we strongly anticipate that this will be our last communication of note with the IBI (save for the eventual submission of the remainder of our evidence; more later), then we request that any transgression of protocol can be overlooked just one final time.

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We have been treated abominably over the last three or so decades and are wearily familiar with the terrain, as it were, of the unsuccessful push for justice concerning the Contaminated Blood Scandal (CBS), our preferred term. We are jaded by experience.

Worryingly, since August, we have begun to recognise certain patterns emergent across the IBI landscape that we have seen repeated several times over the years, notably through our involvements with: the UK Government; individual medics; British politicians of all stripes; the Haemophilia Society (HS); the General Medical Council (GMC); the media; and the Archer Inquiry (AI). We have also started to detect, of late, similar refrains that we are well attuned to.

Essentially, we are, sadly, well worn enough to be able to not only read-between-the-lines of the unfolding IBI process of late, but also listen betwixt.

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We had once dared to believe that the IBI would finally be a platform through which we could achieve justice, and further that such could be served without our experiencing any further injury in the process. We now not only know that the latter hope has been shattered, on several levels, over the course of the last few months, but also deeply fear, and with good reason, that the former goal will ultimately not be realised either.

In short, we have travelled down this damaging road before and are witnessing the same warning signals appearing in our sightline. Unless we are re-assured otherwise (and we don't believe that scope to do so now exists) we would prefer to essentially cease our IBI journey herewith; cut our emotional losses and repair before too much further damage is suffered.

For although we have listed, above, a varied range of third-parties and occasions through which we have suffered greatly over the last few decades, we would specifically highlight the very last cited: the AI in 2007.

That was a process that we:

- were initially highly reluctant to become involved with;
- eventually embroiled ourselves within quite extensively;
- and then suffered deeply as a result

It took us many years to recover from the injustices we endured at the AI. It was why we were initially wary of becoming too involved with the IBI. Yet we have done so. And yet, once again, we can see and hear the same signs and sounds emerging.

We simply cannot afford to invest ourselves much further, despite wishing to retain what we intend to be a purely default status as non-proactive Core Participants.

Accordingly, we supply our rationale for coming to our very reluctant conclusion.

Concession

Although we maintain that we have never caused our own suffering at the hands of all of the disparate parties and entities listed above – not even once, despite the statistical likelihood that there would surely have been at least one isolated occasion – we concede that the decision we are communicating today is at least borne, in part, of our especially guarded attitude to any and all dealings with officials and others attendant to investigating the CBS.

We admit that our barrier is perhaps too high; but with good reason. Indeed, our expectations are so far below zero in every unfolding micro or macro instance of matters pertaining to the CBS, that there is likely no chance of us ever reaching even a point of neutrality, let alone single degrees of faith.

The reluctant decision we are hereby communicating is surely yet another bad fruit of the totality of rotten experiences we have endured over the decades. We know that. Perhaps, also, we have become our worst enemies, we concede that too; an ultimate irony of the long CBS campaign.

Nevertheless, we feel that we are caught in yet another vicious circle from which we have no escape, other than to, self-protectingly, put our forward motion into a sudden and dead-stop.

The seemingly ever-vexed question of our communication channels with the IBI

This has been the unfortunate subject central to the exasperation that we have endured since August, which appears to have no resolution that we could identify without us incurring at least a degree of jeopardy. Something we are not prepared to undertake. We are not unnecessary gamblers.

The matter first arose, benignly and with fair justification, at the IBI introductory meeting with potential Core Participants in Liverpool in July 2018. We were informed that we would not be influenced by the IBI, one way or the other, as to whether to seek legal representation alongside our inquiry involvements. However, we were also informed that if we were to choose legal representation, then any communications with the IBI must be channelled through our advocates – unless we were to instruct otherwise. Our understanding was that in the eventuality of us choosing legal representatives, then our very first communications must necessarily be filtered through our advocates. However, if we were to then indicate a desire to contact the IBI directly, then such, apparently, could be accommodated, providing that we made it clear to all parties.

It was a relief for us to hear the above. Or at least intuit what we thought we heard (which we hold is an accurate representation of what we perceived). For it afforded something of a clinching moment for us. As said, we were reluctant to become heavily involved with the IBI unless we could gain certain guarantees about the process (Gregory had a list of 24 questions to put to the IBI team at the FACT cinema location in Liverpool, and had them prioritised in the expectation that he would only be able to realistically present two, or maybe four; as it transpired, due to the reluctance of others to speak publicly, he was able to plough through his entire list whilst continually re-checking that he wasn't being too dominant).

At the very top of our list were matters pertaining to legal representation and also that of "*sacred cows*" (our term). Regarding the latter instance, for example, we presented a list of public names and entities – e.g. Bill Clinton, Tessa Jowell, Andrew Burnham, the AI, John Reid etc. – that we expected the IBI would surely encounter were it to do its job properly. In our full expectation that the investigators would necessarily uncover certain negative aspects concerning the CBS and the above named identities and entities (although some positive angles, also, undoubtedly), we asked whether there would be any "*sacred cows*" (a clumsy phrase).

We were informed that the investigation would follow wherever it was led. That, and the assurance about the potential fluidity of communications – potentially running parallel to legal representation – essentially assured our involvement, which was a mighty leap of faith for us. For we knew that the evidence that we would supply would be complex and not easily summarised. Nevertheless, our self-protecting guard had barely been lowered. For we are a deeply bruised family set.

Thereafter, the question about legal representation was a counter-intuitively easy one for us, despite our being perennially wary of all third-parties, as a matter-of-course; for which we issue no apologies. We instantly identified a self-protecting system of checks-and-balances: i.e. having the benefit of legal representation if we felt that the IBI wasn't progressing as we would have anticipated; equally, having direct recourse to the IBI in terms of processing our full evidence (i.e. not summarised or bullet-pointed), which we knew would be extensive and that we wished to handle exclusively ourself (we have triply unfortunate experience of entrusting third parties with dissemination of our evidence and were of no mind to risk such for a fourth time).

Similarly, the question of whom to choose as our representation was also easy: Leigh Day. We GRO-D GRO-D GRO-D Regardless of how the Department of Health then scandalously scuppered the case circa late 2018 and 2019, crassly using the very existence of the IBI as a means to delay and deny interim justice for those like our mother (a matter that we impressed upon the IBI at the Liverpool meeting on February 18th, 2020, seemingly to no avail; more later), we still hold by our decision to opt for its services and no other. For at least it tried.

Accordingly, we felt both assured and insured enough to begin preparing evidence. You have seen the first submission that we made in July 2019. Accordingly, you'll know how big an undertaking it was to even begin committing ourselves to that arduous and distressing process.

To our best recall, we then had little cause to involve ourselves much with either the IBI or Leigh Day during late 2018. However, in early 2019 – we believe circa February/March, perhaps later – we felt that we had to contact the IBI directly.

Simultaneously, we were also fine tuning, with Leigh Day, the practicalities of us requiring occasional and direct contact with the IBI. We encountered no obstacles and the instance was quite organic, with no little measure of courtesy attendant to the sequence, which we appreciated.

Essentially, a series of calls (albeit lengthy) and emails ensued which centred around the emerging reality that our evidence submissions would not be routine (for want of a better phrase) and also a concern of care that Leigh Day expressed that we were somewhat isolated, despite being folded into its Core Participants (n.b. the matter of our named status as Core Participants also needed to be finalised which was a perfect case in point for our perceived need for representation; for we had no idea how to address that aspect and so appreciated legal help – the very definition of – to assist us and spare any concerns on that front).

All told, the communications sequence that we experienced in spring 2019 amounted to a necessary episode of good housekeeping. We were assured that Leigh Day were there for us as safely net if needed. We wished that to be so. We also wished to keep a direct line to the IBI as an option, certainly during the prolonged process of our evidence compilation (which only we knew the likely duration of). The broader resolution – if that is the appropriate term – seemed satisfactory to both ourselves and Leigh Day and would still seem to be so. Unfortunately, as witnessed since August 2020, the IBI no longer appears content with that triangular arrangement.

We initially couldn't understand why such a smooth process was suddenly, and we think unnecessarily, thrown off-course. For it was working perfectly for us as Core Participants (a family that has suffered much, when all is said and done), as evidenced by our communications with the IBI of 8th May and then 25th July, 2019 (we have hardly inundated officials with correspondence). Surely that’s paramount? Peace-of-mind for those who have suffered decades of hurt through the CBS?

Conversely, though, we now suspect we know exactly what, or rather who, has influenced this late disruption, though to what extent we couldn’t say. Namely, our father’s former haematologist. For the events that have unfolded since August 2020 seem to bear all the hallmarks of his previous behind-the-scenes interventions to stymie our push for justice. Ironically we have only learned the true extent of all this in these last months, indeed weeks, indeed exactly as our relations with the IBI have begun to cool – through no deed of ours.

We instinctively knew, then, since August that something had obviously gone awry in our relations with the IBI and could not initially fathom why. We now believe it obvious.

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We first made proper contact with the IBI in early 2019, i.e. subsequent to the Liverpool meeting of July 2018. We spoke to Mr Moore by telephone. He didn't remember us from the gathering, yet that was to be expected, for we are among hundreds of witnesses and, at that point, there was nothing necessarily memorable about us, save that we had perhaps dominated the occasion. Our concerns in contacting him were twofold.

Firstly, we had believed (wrongly, we now know) that we were about to miss, by a mile, an evidence submission deadline of spring 2019. Whilst our initial draft of first evidence, at that point, was over 60,000 words (although greatly expanded by arduous transcription of medical documents that we were determined to identify in advance for the IBI, rather than leave it to chance that they would ever be unearthed), we knew we were still nowhere near completion.

Secondly, we had reason to fear that our father's former haematologist at the Royal Liverpool University Hospital (RLUH) was about to be invited as an expert witness, much like he had been, say, at the Penrose Inquiry. However, our conversation with Mr Moore (through Gregory) was positive on three fronts. We were eased about our evidence submission and also regarding the doctor we had deep concerns about. Further, though, it was our first experience of the assurances we had been given the previous summer, about the required and occasional fluidity concerning our sporadic communications with the IBI.

All was well and we had no reason not to push on. Nevertheless, we again concede that our self-protection mechanism was still at its highest level.

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Eventually, we were able to submit the preliminary draft, of the first part, of our evidence in July 2019, covering from November 8th, 1968 to September 3rd, 1994, our father's death. It was a perversely momentous milestone. For it meant that for the first time we had been able to compile the full extent of our father's suffering and commit it all to text – as much as can be the case anyway – and furthermore trust that it would be read, in-toto, regardless of length, by at least one other person. That was a massive psychological hurdle to finally overcome; yet it obviously gave dubious reason for satisfaction considering the contents. If nothing else emerges from the IBI in our favour (as we now suspect), then at least we have solace in knowing that we did our very best for him.

We then reasoned that we just had to repeat the process with the second part of our evidence, i.e. from September 4th, 1994 to the present, in order to communicate the flip-side of the story, i.e. the full extent of our mother's suffering these last 26 years and more. However, we knew that such would perhaps be an even harder task to document (the IBI doesn't know barely a quarter of what she has resolutely endured).

We were still preparing that evidence in August 2020 when, on the 13th, we were, somewhat courteously (our caveat reflects the short-notice that we were afforded), alerted to the imminent publication of an evidence file relating to the complaint that we took to the GMC in 2004 concerning our father's former haematologist.

As we conveyed in the response that was requested of us (we wrongly assumed), concerning that apparently necessary file-sharing (some materials we historically knew of, others – quite distressing to read all these years later – we had no idea of), we were greatly dissatisfied at the bottlenecked procedure requiring our hasty comments, i.e. less than a week later.

We were reluctant, though, to communicate our distress concerning that episode (which ironically was a seminal one for us, or so we initially assumed). For we had once before dared to express dismay to officials investigating the CBS, namely the AI, and subsequently paid a price for doing so: i.e. our evidence was completely omitted, save for a few token nods, in its final report, and we've never had an explanation as to why; ironically that whole distress from 2007 now forms part of our IBI evidence submission.

Indeed, in daring to communicate our late dissatisfaction, to the IBI in August 2020, we ironically referred to our previous complaint to the AI, expressing the view that history seemed to be repeating itself. We barely realised the half.

We did not anticipate that our entirely justified complaint to the IBI would then further go on to replicate that of the AI by evidently corroding our relations, in late 2020, in much the same manner as in 2007. Twice we have dared to justifiably complain to established entities that we had thought empathetic to our cause, and twice we have been been left to regret it. Nevertheless, we stand by our actions both times.

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Our hasty dispatch to the IBI in August 2020 implicitly reflected our ongoing understanding of the smooth communicative processes between ourselves and the IBI/Leigh Day; i.e. a seamless, triangular communications channel. However, under normal circumstances, had our reply amounted to nothing more than a paragraph, or a no-comment, we would surely, we believe, have merely communicated such to Leigh Day only, and not necessarily bothered the IBI. For example, we've been quite satisfied, since 2019, that episodic returns of our re-formatted evidence have been singularly channeled through Leigh Day – and securely so, with padlocked procedures which have been a most appreciated and re-assuring element.

However, we knew that the occasion of August 2020 was not a routine circumstance. For, once again, our response was hardly brief (although we believe we did well limiting our views to just 15,000 words or so; we could have said much more). Again, we would stress that an over-arching anxiety for us, in requiring a fluid communicative process between ourselves and the IBI/Leigh Day (in addition to our admitted high caution) was simply reflective of our prior knowledge that our evidence submissions would never be simple. Further, concerning the August 2020 episode, we also knew that other factors were pressing against the very tight timetable (e.g. holidays, a seemingly strict deadline that we'd missed; and of course the pandemic disruption).

Our course of action, in submitting our response to both the IBI/Leigh Day, was entirely sensible and didn't deserve thinly-veiled admonishment. Moreover, we naively believed that our diligent double-outreach would actually be appreciated by all parties.

As evidenced by Leigh Day's immediate courtesy response, the process was known and acceptable. Further, we could not have anticipated Mr Moore's absence prior to receiving his out-of-office auto-reply, which, in turn, seemed to justify, even moreso, our subsequent action in ensuring that our response was then swiftly re-forwarded to Mr Milburn as a safety measure (n.b. again, it was a concern for us that we knew that we had already missed a deadline by a day, however harsh a timetable we believed we had been set, and we naturally didn't wish to have wasted our time drafting 15,000 words; as it it transpired, that's exactly what we did).

The irony of the whole episode was that in our final action, we actually expressed to Mr Milburn that we did not require a reply – we really didn't – for we knew how stretched the IBI was at that point, and indeed at every stage.

Regardless, we eventually did receive an unsought reply, sent from the IBI to Leigh Day, and it was, frankly, doubly unnecessary. It was couched in aloof corporate-speak and detectably irked in tone. Further, we saw in the accompanying dispatches that significant emphasis was necessarily being placed on the fact that the reply was being channeled only through Leigh Day – the inference being that the benefit of fluid communications that had prevailed since early 2019 was to be curtailed and we were to understand as much, as though we'd transgressed some protocol that we were previously unaware of, save for the courtesies described to us in Liverpool in July 2018. Additionally, and quite signally, it was striking that no qualitative reference was made to the distressing aspects – concerning the wellbeing, or not, of our mother – that we had reluctantly but necessarily aired in the final part of our submission.

All told, there was more than a hint of dismissiveness and distancing in the IBI's strained tones, and we do not believe that we have merely formed our perception of such as a default result of the ultra-guardedness that, once again, we freely concede we roundly possess, perhaps to a fault.

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Consider that we were given less than a week to submit our response and only missed our deadline by a single day, yet still made every effort to ensure that it reached the right quarters as expressly as possible.

Consider also that when we initially received that file on August 13th, we were not supplied with any additional advice as to what exactly it was we were being asked to respond to; for example we initially could not make head-nor-tail of the linked documents (which bore at least three confusing numbering sequences as far as we could ascertain), and especially so when noticing that its lead page actually referred to the evidence of anonymous third party, yet it bafflingly (at first) seemed that materials relating to our father were being used materially in that regard (in principle we have no problem with such, but it would have been courteous to explain as much in advance, if indeed we are correct in that interpretation - for at the time of writing we still do not know for certain, which is a measure of how bewildering the process was for us; if you could possibly put yourselves in our shoes as completely passive recipients of that virtually unexplained file, then you would understand as much).

Consider further that there were documents in that haphazardly sequenced file (genuinely, it took us a day-and-a-half of cross-referencing to finally get a workable overview of exactly what we were dealing with before we could even begin to draft our reply) that were hugely distressing to read. Yet still we hit the ground running and provided what we naively assumed was a qualitative submission. Furthermore, we even went to the extra lengths of transcribing supplementary materials from our own files in order to assist the IBI further.

We could not have done more to assist the process, at break-neck speed and in ensuring it reached the right destinations.

Yet our efforts and willingness (and more) were barely (caveat) reflected in the lines that we could only read between within the IBI’s detached response, which didn’t even have the courtesy to address us as Mrs Anakin and Mr Murphy.

For example: *“The purpose of our email dated 10 August 2020, was to notify you of the upcoming disclosure of the GMC material and provide you with copies of the redacted material for brief review. Our intention was not to invite lengthy submissions, but rather to provide you with a notification as a courtesy and as an opportunity for Leigh Day to raise any pressing issues relating to the disclosure of the GMC material and the redactions contained therein.”*

Might it not have helped, then, to have expressed that initially? Believe us, we would have appreciated not having had to drop literally everything at a moment's notice (not for the first time in our long campaign for justice) in mid-August, in the midst of a pandemic, and compile our response - which ironically and apparently wasn't even wanted.

Further, and with detectable exasperation: *"The Inquiry's counsel team have reviewed and considered the GMC files in their entirety already…"*

Yes, that much was obvious. We knew that.

As it was, we were already distressed at reading some of the materials that we had been sent. But we were then shattered to read the IBI's uninvited response (did it really need to be sent?) which was devoid of cordiality. Regarding the caveat we supplied earlier, we recognise that the IBI did in fact include, towards the end of its communication, a brief appreciation of our efforts. However, not only did that seem tokenistic but even then it was accompanied with a somewhat censorious rejoinder:

"Whilst we are grateful for the additional information provided by Mr Murphy and Mrs Anakin, their response is more appropriately reserved for inclusion within their witness statement."

Really, what were we to make of that distant air? We would say, bluntly, that we have made of it exactly what was implicitly conveyed and was surely intended for us to intuit. We are not fools. It was a truly jarring moment and we could initially only conclude that, once again, as per our experiences with the AI in 2007, we were feeling the draughty effects of even daring to complain to the IBI.

Immediately, we reasoned that if the IBI was capable of reacting with such detectable peevishness – let alone having expected us digest a huge evidence file and respond to it (or not) within six days (utterly unjust) then it perhaps wasn't, after all, the platform through which we could expect justice to be served. Something had changed; we could tell that even before our submitting our response.

Sensibly, we held off from further comment (save necessary courtesy and holding communications with Leigh Day) and resolved to keep our counsel until we could regather ourselves. We had to let our emotions subside; we know the bruising terrain of the CBS well.

We detected that Leigh Day, as a matter of duty, necessarily had to impress upon us that the previous system of fluid, triangular communications (again, only when necessary, and indeed very rarely resorted to) could no longer apply. Essentially, we realised that we had no choice but to re-address the dichotomy that we were first presented with in July 2018 and then thought we had resolved in early 2019: i.e. either restrict our intended major communications to the IBI through Leigh Day; or recklessly (in our view) abandon any legal representation and accompanying peace of mind and liaise directly with the IBI itself. Essentially, we were no nearer, in autumn 2020, to being able to make a choice between those two stark options than we had been in mid-2018, for the very reasons adverted to right at the start of this submission.

Incidentally, Leigh Day has dutifully expressed to us that we might indeed benefit from cutting our ties with its representation and liaising directly with the IBI. Let that not go unsaid. However, we just can’t know that for sure. For it could prove to be that abandoning all legal representation became one of the worst decisions we ever made. We can only ever err on the side of caution, dealing with knowns and not risking unknowns.

The above said, we nevertheless knew that one aspect had regrettably changed for us, which made it more unlikely than at any stage for us to take a risk and abandon all legal assistance. For we already knew, by dint of the IBI’s unnecessarily strained reply in September 2020, that we were no longer prepared to take the foolhardy gamble of eschewing legal representation regarding what is, after all, very daunting participation in a major, national public inquiry that we still (at that point) didn’t necessarily have a handle on. Unfortunately, we now believe we do.

Certainly, we were hardly prepared to abandon legal help given our experiences of the last three decades or so. And then most pertinently not subsequent to the jarring tones of the IBI’s entirely unnecessary response to our August submission. Regardless, though, we knew we had a decision to make. However, it rather extended beyond the already moot decision as to whether to channel things solely through Leigh Day or the IBI (the latter no longer being an encouraging option).

Rather, it went right to the heart of whether we retained any desire to continue any *proactive* involvement with the IBI. The unfortunate episode, even to that point, had served to crystallise several things – especially given our deeply painful AI experiences. The maddening and acutely distressing events of the past fortnight have only brought matters even further into sharp focus

Incidentally, to digress on a tangent briefly, we have, during the course of our, admittedly distressed, holding-communications with Leigh Day since August, referenced our suspicion that our stated intention to criticise the handling of the AI within our evidence, no matter how churlish that may seem to some, is perhaps an inconvenience for the IBI that may have been among certain contributory factors behind the growing coolness we have detected of late. Further, we have also considered that perhaps even our stated intention to expose certain hugely hypocritical and damning aspects concerning Mr Andrew Burnham's involvement with the CBS, and his email communications with ourselves to that effect in 2012 and 2017 – that only he and ourselves know about at this point, which we intend to bring to the fore one way or another, though not necessarily now through the IBI (most certainly given that he has, once again, been reflected in entirely undeserved glowing terms in a recent TV documentary relating to the CBS), may also have been an awkward strand for the IBI to contemplate.

We may be wrong on both counts. Yet we include those micro-lines of thinking as a signal measure of just how tensely-wired and circumspect we are, on a permanent basis, about literally anything and everything connected to the CBS; we are microscopic towards every utterance and syllable ever forthcoming. It's certainly a horrible psychological hazard that we've developed but it's always to the fore nonetheless. We are products, indeed victims, of our environment and experiences. Yet, we are bound to say that we have been correct in our suspicions, at various junctures over the last 30 years, vastly more than not. As the evidence that has emerged concerning our father's former haematologist earlier this month has ironically proven to us.

As alluded to, we concluded, in late September, that essentially the only choices we had to make revolved around our further levels of involvement with Leigh Day only. For, as said, the question of us seeking to ensure direct communications with the IBI no longer applied. Can you blame us?

Our options, then, as they appeared to us, were: i) pursuing *active* further interest with the IBI through Leigh Day; ii) completely detaching ourselves even from Leigh Day as well as the IBI; or iii) retaining a token status with Leigh Day, almost on a default, pragmatic basis, just in case the IBI develops in ways that are further injurious to us (and given the developments of the last two weeks alone, it was a seminal lesson to us of the innate wisdom we applied by withholding our decision from circa mid-October until this point).

We communicated to Leigh Day that we would wait until our father's former haematologist had given his evidence before finally communicating our stance (we again stress that Leigh Day has not pressured us and has communicated its corporate appreciation of our complex situation with necessary courtesy).

In doing so, we laid out certain reasons for waiting until at least November 6th before finally concluding as to how we would progress further, if at all. To supplement that, we here share part of a distressingly drafted e-mail communication that we sent to Leigh Day in this regard on November 2nd:

"*Wednesday and Thursday are going to be very hard for us (even moreso knowing that our mother will not now even be aware of his planned appearance - having completely detached herself, probably sensibly, from the Inquiry's proceedings after so many decades of wasted campaigning)…*

"*…As an insight, we've actually experienced nightmares about his planned appearance (Mr Moore at the Inquiry probably won't recall a deeply anxious phone-call that we made to him, circa February 2019, back when we thought we could approach him directly that is, when we were anxious that the medic in question was going to be called as an expert, as per his involvement with Penrose; at least we've been spared that grandstanding aspect)…*

"*…That's a measure of just how much a spectre his planned appearance has cast over us since we first learned of the autumn schedule (although we always knew the day would come sooner or later)…*

"*…Our plan is to at least start watching the proceedings on Wednesday; whether we are emotionally able to continue to do so will be another matter; the experience will be somewhat akin to inviting him into our homes. If we find that we are not able to stomach several hours across two planned days in his dubious company no matter how remote - we've no idea how we're going to react to be honest – then we will have to wait until later in the week to read the transcripts of his no doubt meandering and ever disingenuous responses. It's been hard enough for us to adjust, since August, to digesting the recent disclosure revelations that we were made privy to concerning his and his legal team's disgraceful chicanery in 2004 regarding our failed medical negligence case against him…*

"*…We have to say, though, that barring a knockout moment, we highly doubt that we will glean enough of an indication from the planned proceedings this week with that man to enable us to make an informed decision as to how best to proceed with our future involvement with the Inquiry. In any case, it's already clear to us that the Inquiry team…has little appreciation of our inconveniently nuanced and detailed evidence submissions thus far (and yet, for some reason, it was our father's case that was repeatedly used as the go-to case in both the House of Commons and Lords, and indeed the national press, in the late 1990s, as the matter of injustice concerning HCV infected haemophiliacs was finally being exposed; and for some other curious reason it was deemed that we should be the very first witnesses at the Archer Inquiry in 2007...regardless of the shocking treatment we actually did receive at Westminster on the day)…*

"*…Without wishing to pre-empt matters ahead of hearing from our late father's haematologist, we would say, though, that in any case we'll likely not choose to deal directly with the Inquiry from here on in…even were we to retain an interest in proceedings. Basically, then, the only decision we would have to make, boiled down, would be: 1) whether to actively continue with Leigh Day and with eager interest in the Inquiry; 2) whether to continue with Leigh Day just purely on a default basis to see how the Inquiry pans out (and to be honest we already know the answer to that – there isn't a prayer that justice will ever be served); or 3) whether, after Thursday's draining inevitability, to completely cut our ties, as per our psychologically battered mother, with every aspect of the Inquiry (if so, our loss-cutting reasoning would be that we've already wasted almost three years of our lives in compiling and submitting evidence, so why risk adding a fourth and maybe a fifth?).*

"*The whole vexed situation that has come out of nowhere to beset us since August (when ironically we initially thought we finally had a breakthrough moment after years of hoping and after submitting Part One of our evidence; we really should have known better) has been intolerable…*"

And then, head-first, we collided, once again, however remotely, with the dissembling nature of the medic in question; we watched his evidence in bit parts between the 4th and 10th November (n.b. it would have been our father's 86th birthday on GRO-C.

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We saw his video evidence prior to reading his written submission.

We make little comment about the majority of his spoken utterances; save that, regrettably, as per Penrose, he was afforded ample opportunity to present himself as a world expert in his field. His leading expertise, since the early-1980s, is a self-evident truth that we have never denied and which our father should have benefited from in the final years of his life. Indeed, therein, has always lain one of the central aspects of our complex and dichotomous complaint agin him: i.e. either he is the world expert he claims and appears to be, which we agree is the case, yet he inexplicably failed to see the tragedy of our father's case unfolding right before his eyes over seven or so years; or he is not quite as expert as would seem (and we're all fooled) and therefore that would explain his litany of errors concerning our father's demise – even down to not spotting that he was suffering in the final six or so months of his life from advanced hepato-cellular carcinoma with an alpha-fetoprotein reading that had already escalated to 9280 some eight weeks prior to his death. We could go on.

However, we have to say that we were stunned at the very personal nature of the evidence he was enabled to vocally present in the second part of his final afternoon. Further, he was even afforded the open platform to portray himself as a victim. That's a powerful combination he was able to convey to all watchers (especially almost immediately after a discussion segment in which the life expectancy of haemophiliacs, pre-treatment era, was roundly debated): i.e. a world expert, operating dutifully amidst a tragedy that he held was "*unavoidable*", wherein attendant medicines were supplied in "*good faith*", yet he was then subject to "*campaigns*", being "*berated…loudly*" in public, by patients or their relatives fixed on "*fishing expedition(s)*", "*feeding frenzies*" and "*low grade guerrilla warfare*". In the shocking admix of all that, our case was interwoven, albeit in a redacted but easily identifiable manner (our case is well known in haemophilic circles). Yet no-one bothered to alert us to the likelihood.

Really, we can count on the fingers of one finger how many times we have been thankful for the almost blanket lack of sustained press interest in the CBS (and to think that the witness before the IBI ever imagined that "*guerrillas*" like us possessed the ability to "*manipulate*" the media; if only). For had a neutral and completely unwitting observer reported those sequences from PM2 on November 5th, we could have been treated to subsequent editorials along the tendentious lines of:

"The Infected Blood Inquiry today heard how a UK-based, world haematology expert endured campaigns of vilification from survivors and bereaved victims of an alleged NHS scandal, whom, he said, were intent on engaging in 'low grade guerrilla warfare', blaming him for treating haemophiliacs with pain-relieving materials, ultimately proven to have unknowingly been contaminated, that he asserted were originally administered in 'good faith' and which arguably served initially to extend the short life expectancy of hundreds of those stricken from birth by the genetic blood disorder, many of whom subsequently lost their lives in an 'unavoidable' tragedy."

We weren't at all surprised at his generic verbal embroidery about the wider CBS and his always convenient mis-representations and mis-remembered details concerning our father's case which he sought, once again, to completely mischaracterise (all of which we could bore through with ease – were we ever afforded the now highly unlikely chance to do so). Interestingly, in 2004, as per the evidence file submitted to us in August 2020, he claimed to only have limited recall of our father (and implicitly our mother), citing a time-lapse of a decade at that point. Yet 16 years further on, and some 26 after our father's death, he is able to recall being "*berated…loudly*" by our mother in a hotel foyer.

Nor were we that astounded at his always unfathomable circuits of logic: e.g. how did we ever expect that pursuance of medical negligence cases agin him would ultimately convince the Department of Health to act justly?

For, all such chicanery we have long since come to expect from him when discussing the merits or otherwise of our push for justice concerning the wider CBS and his incidental involvement amidst the whole tragedy relating to our father.

Rather, though, we were astonished that he was allowed, at some instances we would say enabled, to express them without us being forewarned of the likelihood that he would get very personal, especially regarding Gregory (*"…the son of one of my patients whom I never saw during his life, despite having a close relationship with his parents…"*).

We were then dumbfounded at certain of the contents amongst the letters shown on screen during his verbal evidence, all of which we were completely unprepared for.

We knew, of course, that, deep-down, he is still in a complex form of denial about the whole CBS, i.e. still citing terms like "*good faith*" and "*unavoidable*"; and we completely reject his stated belief that a Public Inquiry should have been held decades ago, for we contend that he'd have been as opposed to such then as he evidently and not so subliminally is to the present undertaking. Perhaps, though, stating as much, so bluntly, is further akin to conducting "*low grade guerrilla warfare*" (we refrained, in the first submission of our evidence, in July 2019, from referring to his regular emissions and self-defending utterances, often being naught but pure projections, as overt "*Hayisms*", preferring to rise above such baseness – however we did include an inserted series of such standout instances within our text – but we can think of no better eponymous description; further, a perfect and perhaps self-damning example of such we will refer to a little further on). Much of that was within our pre-honed mental budget of tolerance, in preparation for having to face him again, so to speak, after so many years. We're long since used to his general circuitousness.

Nevertheless, when we realised, subsequent to his video testimony, that the IBI hadn't even extended to us a simple courtesy of forewarning us of the quite obvious potential for matters to get very personal on-camera, nor having flagged to us the existence of his written statement (it has since come to our attention that the document has been in the circulation since at least October 26th), then we really had to steel ourselves prior to reading its content.

We were already reeling from seeing his on-camera posturing. But we were then left utterly floored after reading his written statement. We hold that the IBI has hung us out to dry and has likely known, since relations cooled in August, that such would be the case. The two aspects go together, we believe. Our evidence has been reviewed and is yet unpublished; his submissions have been duly considered also, and yet cleared for publication. It's seems quite clear what conclusions the IBI has drawn. We concede that he is a very convincing chap. Unfortunately.

It was deeply upsetting to learn that he had long since implied that Gregory – through his cleverly ambiguous "*…the son of one of my patients…*" invective (from November 1994) – was motivated by chasing money subsequent to his father's death, when he had, according to the professor's erroneous recall, been implicitly absent from his medical demise since 1991, "*despite*" (a loaded use, and no mistake) his "*close relationship with his parents…*". That much of a theme was also evident from his representative's passive-aggressive submission to the GMC in 2004, which we were only made aware of by the IBI in August 2020.

For the record:

- Gregory first met our father's haematologist in the late 1980s, and then again most notably in January 1992, as per our first evidence submission, at the RLUH when he was jointly diagnosed with both Hepatitis C and cirrhosis of the liver; in fact it was Gregory who finally pressed his father's medic into communicating a likely (and unerringly accurate) timetable of his father's likely descent towards death;

- moreover, Gregory was at his father's bedside when he finally died on September 3rd, 1994 – after four near misses between April 1992 and August 1994; yet his haematologist wasn't there for any;

- Gregory, had also wheeled his desperately weak father around the grounds of the Newcastle Freeman Hospital in August 1994, during his admission for tests ahead of a potential liver transplant, which was already a medical non-starter given that his father had long since developed liver cancer that Dr Hay and indeed Dr Gilmore had completely failed to spot;

• further, Gregory, just weeks later, then felt the very, very last vestiges of isolated warmth in his father's emaciated flesh, an hour or so *post-mortem*, and then travelled home with his blood on his shirt – a souvenir of many of the failed injections that horrendous day – where it remains unwashed to this day;

• also, Gregory has now been stuck in the middle of an uncompleted conversation with his father for over 26 years, curtailed in the hours prior to his death due to the increasing effects of administered morphine;

• finally, Gregory, with his wife, was again at the RLUH for several hours on the morning of September 5th, 1994, less than two days after his father's death, in the deeply traumatic episode seeking to acquire his death certificate (painfully described within the attached raw evidence file, which we trust may be of interest to the IBI); it would be interesting to know if his father's haematologist was also present at the RLUH that morning, for he certainly didn't make himself apparent.

It was truly despicable what the medic in question wrote to Mr Barker, of the Haemophilia Society, in November 1994, concerning our attempts to publicise our push for justice, which we've had no idea about for over a quarter of a century. But it was astonishing to see it exposed on-screen in all its ingloriousness, no matter the redactions (incidentally the index to the witness's evidence clearly states "*Murphy report 1996*"), without us first being forewarned by the IBI as to how potentially distressing things could – and most likely would – be for us.

Did we not deserve such courtesy? Or did we relinquish that right when daring to criticise the timetable surrounding the evidence submission that we received in August 2020?

What was even more egregious, though, was to then read – again unpreparedly – the further gross distortions contained in the medic's written submission. Particularly his accusation that our mother had "*berated*" him "*loudly*" in a hotel foyer in November 1994 (shortly prior to drafting his appalling letter to Mr Barker a week later). The witness then added, in his written submission, that "*she then attempted to litigate me*".

We include that last aspect in order to underline that, for once, our father's former haematologist correctly recalled the right chronology of events. For the chance meeting that occurred, with our mother and Gregory, at the De Vere Hotel, Coventry, at lunchtime on Saturday, November 19th, 1994, was indeed prior to our first pursuit of medical negligence against him (and potentially other parties, at that stage), whereas in his verbal submission to the IBI on November 5th, he seemed to suggest that it occurred either after or whilst such proceedings were occurring.

Further, it was largely (though not exclusively) as a result of the jarring meeting (though not for the reasons stated in the witness's evidence) with the medic in Coventry, however fleeting, that our mother was then emboldened enough to approach a solicitor, which she duly did in the immediate week thereafter (as per our attached evidence).

Whilst we completely reject the witness's version of events concerning that Coventry meeting in November 1994, we would, rather than clarifying matters here, refer you to our attached file of uncompleted, draft evidence which describes the occasion more accurately. However, we would stress that we are a conservative family, after our father's values; we don't publicly disgrace ourselves. We take great exception to the clear and sadly now (inexcusably) published inference, regardless of redaction, that any of us would ever do so, especially just weeks after our father's death. That was a gross and very unfair misjudgment by the IBI.

Specifically, also, we would further draw your attention, in the accompanying document extracts file, to our transcription of the letter (item 266; dated Monday, 21st November, 1994) that our father's haematologist sent to our mother just two days after the meeting in Coventry, i.e. the very first working day thereafter and his first, evidently anxious, opportunity to do so, presumably having mulled over matters through the remainder of the weekend prior. Does it read like a letter that someone would write to another who had "*berated*" him "*loudly*", and implicitly publicly, in a hotel foyer just 40 or so hours earlier? Or does it rather read like a letter from someone who knew he had something to be very concerned about?

As said, our mother does not "*berate*" anyone (not any of us). We can say that, categorically, simply because not only would she never do so through her own sense of self-dignity, but she actually does not possess the animal ability to do so even were she ever so inclined.

For she is a timid, church-going individual, and sadly even more shrinking now, aged almost 83, compared to how she was aged 56, less than two months after her husband's death. Rather, she has always possessed a more powerful and unnerving ability to turn occasions like her meeting with our father's haematologist into an ice-filled, socially-freezing episode. She does not suffer fools. Through well-honed combinations of stares, silences and facial expressions, she, rather than "*berating*" him, left him completely un-nerved. That much was evident as Gregory can testify to, despite both his and his mother's lack of wider recall of the finer details of the moment, for the disturbing reasons given in our attached raw-evidence description.

The medic, having encountered our mother for the first time since our father's death, had attempted an air of saccharine unctuousness, extending belated condolences, and an inappropriate over-familiarity. He was met with a glacial wall in human form. He was not "*berated*". Hence his nervous letter just two days later attempting to placate matters. Furthermore, it was obvious to us then, and even more so now, having been made aware of his other actions around that precise period, that another large cause of his anxiety was that he then surely realised, perhaps for the first time, that she knew far more about the precise sequence of medical events surrounding our father's referral to the Newcastle Freeman Hospital in August 1994 than he had ever imagined.

We would stress, as per our enclosed raw-evidence, that the meeting in Coventry was the first time our mother had encountered the medic since a very brief episode in the RLUH corridors very shortly after our father's return from Newcastle in August 1994. Apart from that chance encounter, lasting just seconds, we believe that our father's haematologist was largely absent from our visibility from circa June 8th, 1994.

We note also that the medic stated that he wrote a report at that time about the events in question, i.e. in the later parts of 1994 (and perhaps earlier, we don't know), apparently numbered WITN3289072. Why have we not been able to see this?

We note also that in 2007, the medic submitted emails to the AI regarding the subject of its "*early witnesses*". Given that we were the very first witnesses at that event (although we may as well not have bothered travelling to London), we would dare to presume that we surely fall into that category, especially also as we possessed a strained history with him. We have no doubt that, chiefly, it was us that he was referring to.

Depending on the precise date of those emails, described as being April 2007, we would speculate that, at long last, we may finally have been able to join the dots about the utterly vexing experience that we endured on day one of that ultimately flawed procedure. For, as we described in the preamble of our submission to you in August 2020, we were subject to a very sudden, and quite inexplicable, last-minute change-of-plan ahead of submitting our evidence to the AI; and having to adjust to doing so live on national television, no less. Every single thing that we had prepared, and was still agreed to as late as circa 10pm the evening before, was completely jettisoned. Further, on arrival at Westminster, we detected a social awkwardness, in some cases complete evasiveness, from those we tried to speak to for clarification in the desperately anxious moments in the half hour or so prior to broadcast. In fact, one individual whom we had liaised with extensively, in the weeks and days prior, was suddenly behaving quite differently, and detectably distantly, upon our arrival.

We simply could not make head nor tail of what had happened. But we knew something had. And further, we knew even by the time we had returned to Euston Station that the AI, upon which we had eventually placed so many hopes – despite our initial reserve – was already dead-in-the-water for us.

We experienced the same type of disquiet – knowing that something untoward had occurred but not knowing exactly what – when we received the evidence file submitted to us by the IBI in August 2020. There was no assistance for us in terms of describing what it was that we were receiving and expected to comment upon (or so we thought). There was no steer about what was expected. Nothing. And further, we were given a hideously short period in which to respond.

The episode was all too eerily reminiscent of our experience on day one of the AI: sudden distancing; vagueness; and an expectation that we were required to adapt to a very complex matter with barely any time to do so.

We dared to complain in 2007 to the AI, and paid the price for it.

We dared to complain in 2020 to the IBI, and are seemingly enduring the same.

For not only did we receive the subsequent terse response from the IBI in September 2020, but we then also realised, whilst digesting the unpalatable evidence submissions of our father's former haemotologist in early November, that we hadn't even merited any pastoral outreach preparing us for the absolute certainty that it would be a deeply distressing experience, and further that our characters would be publicly besmirched. Yet we note that there is such an IBI entity as the "*Engagement Team*".

Further, all of this was set against the backdrop of us having communicated, in August 2020, the additional distress that we have unfortunately experienced with our mother, as this dreadful year for all has unfolded, indeed as a direct result of the IBI's very existence – as described in our August 2020 preamble.

To put all this into perspective:

- in August, completely from the blue, but without any informative assistance, we were apparently afforded the "*courtesy*" of being alerted to the fact that evidence relating to our father and us was being used in connection with an anonymous third party, and not our own case;

- yet in November, we were denied any such courtesies, when evidence was placed into the public domain this time relating directly to us and tarnishing our reputations into the bargain.

If we're incorrect in those perceptions, we would appreciate an explanation as to why or how.

Further, we could only note that despite our first tranche of evidence having been submitted to the IBI in July 2019, despite it having been re-formatted (to our satisfaction) by October 2019, despite us having submitted our trio of signatures in mid-March 2020, our submission still hadn't been published by November 2020.

Yet our father's former haematologist was not only afforded the opportunity to appear before the IBI, presenting himself as the world expert that he undoubtedly is, and feigning an air of victimhood, but also to have his often specious evidence published.

We also note the date of his signature: October 7th, 2020. From our own experience, we doubt that his evidence arrived at the IBI for the first time, in finished format, on that very date. Rather, we suspect it likely, and quite naturally, went through stages of draft iterations for several weeks beforehand. We can't help but conclude, then, that perhaps the first emergence of his evidence occurred in the late August to mid-September period of 2020, roughly around the same period that the IBI began to cool towards us. It would rather make sense of events.

The very fact of the matter, as things stand, is that our father's former haematologist's evidence, denigrating us, and our mother especially, is now currently in the public domain and has been for over a week as we write this, whereas ours is still nowhere to be seen in order to balance matters.

If there is a method in the IBI's structuring of such, then we simply wouldn't know. For apart from occasional courtesies in mid-2019, we have heard nothing of informative note regarding our evidence since. Yet, despite that, we somehow managed to provoke that terse response for daring to register our dissatisfaction about the events of August 2020. That, in a nutshell, is the only qualitative IBI feedback we have ever received; effectively a reproach.

To put things further into perspective, since August 13th, 2020, we have:

- distressingly been made privy to the extent of our father's former haemotologist's malign influence over the proceedings which we undertook with the GMC in 2004, in which his legal representative completely besmirched our characters;

- received a terse response from the IBI after we had gone out of our way to assist with processes, and more, at almost a moment's notice (which we dared to complain about given our past experiences);

- endured the experience, however remote, of having our father's former haematologist before our eyes once again, in both visible and written forms;

- suffered our characters being roundly besmirched by him in the public domain, especially in written form;

- learned to our further distress that he had not only sought to muddy the waters in November 1994 as we first attempted to raise public awareness of the scandal that had befallen our father, but also that he had most surely been the root-cause of the injustice we endured at the onset of the AI in 2007 which took us years to recover from;

- and watched and waited, without resolve, for our evidence to appear in time for his appearance, all the while knowing that a direct request to the IBI in this regard would be unwelcome given the sudden, quite Archer-esque, freezing of relations that surfaced in September 2020.

This is not how our experience with the IBI should have panned out.

We cannot escape the gnawing feeling that the witness, in much the same way as he sought to stymie our media awareness efforts in 1994, heavily influence the GMC in 2004, and disturb the AI in 2007, has again thwarted our push for justice via the IBI, through his malign methods.

It is a deep sore to us now that his main evidence appearance has come and gone without challenge and that ours seems to have been sidelined.

Another tangential digression: our evidence was replete with nuances, one of which we advert to specifically, concerning Dr GRO-D and his care of our father at Christmas 1992: you will see that we drew explicit attention to his unacceptable verbal and written off-handedness; yet we have noted from another witness's published evidence, from another part of the country, that the doctor in question was also cited for being dismissive in tone and attitude in another episode, which seems to suggest not only a personal trait but also, as we stressed, a reflection of how unacceptable the behaviour of certain medics was, right in the eye of the CBS storm as it was unfolding, towards patients who were suffering and dying as victims of one of the biggest scandals that this nation has ever known.

Have passing vignettes like that from our evidence submissions ever been linked to similar in others' testimonies? We have no idea, because, as said, we have received no quantitative feedback from the IBI about our submissions, save for the coldness we were met with by email in September 2020.

Our further fear is that like many parties that have gone before, in the damnable history of the CBS, the IBI will be the latest to inexplicably be convinced by the knowing craft weaved into the evidence of our father's former haematologist.

For example, on November 5th, in relation to someone else's involvement with him, he ventured forth a typical stream of consciousness, stating: *"You know, why should we edit his notes when he's not even trying to sue us?"*

Truly, there are levels of subliminal thinking and tendencies unwittingly exposed in that very heated outrush that were frankly disturbing, but not surprising, to hear. So what if the person in question had been trying to sue? It doesn't bear thinking about. Yet, that was another outpouring of his that goes to the generally incontinent "Hayisms" that we adverted to in the first submission of our evidence. It was deeply disconcerting that such went unchallenged by the IBI.

We also can't help but note that the evidence file that we received in August, that we mistakenly assumed we were required to respond to in just six days, in order to facilitate its publication at the end of that month, actually still hasn't been published, as far as we can see anyway. Did that deadline ever exist then? Or did we unwittingly disrupt matters by virtue of our response? Again, we wouldn't know because we are in an information vacuum, save for knowing all too well that the IBI began to cool towards our efforts of assistance in late August, 2020.

Further, we note that we are invited to attend Zoom meetings; in fact we have always been encouraged to attend the national circuit meetings at provincial locations, two of which we have attended, in July 2018 and February 2020. Yet aren't these direct contacts with the IBI wherein anything can be said, within reason?

For example, those who were at the Liverpool meeting in February 2020 – the revelations within which completely scuppered our mother's faith in the IBI (though not ours at that that point; indeed quite the opposite, as described at the end of our August 2020 submission, ironically) – will know that it was dominated by two exceedingly vocal personalities (and we have no issue with that, not after 30 or so years of suffering and failed campaigning; for people are devastated). They both assumed a free forum to say precisely what they wished. We simply don't see the logic behind being able to express ourselves freely in Zoom meetings or at provincial locations but not being able to approach the IBI directly concerning our evidence submissions. It goes to consistency, surely?

In any case, we did make a brief verbal submission at the February 2020 meeting in Liverpool. We expressed our dismay that the Department of Health had scandalously used the very existence of the IBI [redacted] and that we would like to hear what the IBI makes of that and whether there are any plans to impress upon the Government that the likely duration of the investigation will inevitably delay this particular strand of justice for our mother for perhaps a further two years, until she is maybe 84 or so, having been widowed three decades earlier.

We have no idea as to what the IBI's thinking on that very nuanced matter is because, again, the only feedback we have ever managed to prompt was the edgy response that came our way in September subsequent to our unwanted August submission.

There's probably not much more we can add in order to adequately express our rationale for our reluctant conclusion to curtail *proactive* involvement with the IBI.

As said, we have enclosed the working file of the second part of our intended evidence. Ironically, we have barely expanded upon this since receiving the file that came our way in August 2020. For we waited, and waited, for those materials to be published in order to see what transpired more widely as a result. Then we were completely blindsided by the response we received from the IBI a few weeks later and have rather withheld making any further progress until we could decide how we were to interact with the IBI from that point on, if at all.

As we’ve said, the irony is that we didn’t feel that we could come to that decision until we had heard what our father’s former haematologist had to say (and write) for himself. Thus we have tiresomely found ourselves in yet another vicious circle.

A further irony is that if the evidence file submitted to us out of courtesy in August 2020 hadn’t been sent (much like there was no similar submission to us ahead of the evidence we were subjected to on November 4th and 5th), then we would surely have completed our second tranche of evidence by now (bearing in mind the amended structure that we adverted to in our August submission – and for which we actually apologised, which in itself is an irony as we now look back at the distress of the last three months).

We intend to finish our evidence. We would ask, though, out of human decency, that if the IBI knows that we are already wasting our time in doing so, then please, just let us know and spare us further misery. For we get the distinct impression that any further submissions from us are likely to be filed with our earlier dispatch. How else are we to interpret things given the unfolding sequences since August?

We are content, of course, for you to peruse the attached evidence as much as you wish, if at all. Again, as per our first submission in July 2019, it would be a huge psychological moment for us to know that even one other person came to know the extent of suffering that our mother pitifully endured particularly in the first three years after our father’s death. We believe that we have accurately presented a synopsis of a truly desperate three years. This was the truth of what happened to us between late 1994 and the end of 1997, not the disgraceful version of events spun to the IBI by our father’s former haematologist earlier this month.

Our only caution would be that the attached is, of course, a still unfinished file. In fact, ironically, in the course of re-checking our facts for this very submission, we have discovered other materials – particularly relating to the events of November 1994 – that we thought we no longer possessed and which we would insert into our file. Assuming, of course, that it’s worth our while?

As said, our decision is a reluctant one. Very. And we stand to be re-convinced otherwise. Failing any such re-assurances, though, we intend to simply remain as a default client of Leigh Day but having all but detached ourselves from the IBI.

We are deeply distressed that it has come to this.

Mrs A Anakin, Mr G Murphy

From: Contact Mailbox contact[redacted]
Subject: Re: [Not Virus Scanned] Communication from Mrs A Anakin, Mr G Murphy (WITN1944)
Date: 16 November 2020 at 9[redacted]1[redacted]7
To: Gregory Murphy g[redacted]

Hello Gregory,
Thank you for getting in touch with the Inquiry and sending these documents. I will pass these on to our legal team here at the Inquiry.

Kind regards,
Aemon Iqbal
Engagement Officer

Infected Blood Inquiry
Address: Fleetbank House, 1st Floor, 2-6 Salisbury Square, London, EC4Y 8AE
Email: [redacted]
Twitter: [redacted]
Tel: [redacted]

On Sun, 15 Nov 2020 at 20[redacted]8, Gregory Murphy <[redacted]> wrote:

> To whom it may concern,
>
> (copied to Sarah Westoby; Leigh Day)
>
> -
>
> Please find enclosed PDF; a communication regarding our further involvement with the Infected Blood Inquiry.
>
> To supplement this, we also enclose, for necessary and relevant information regarding the above, the unfinished working files (both PDFs) of "Part Two" of our intended evidence ("Written Statement" and "Document Extracts"), covering the period from September 5th, 1994. As stressed in our main communication, it is to be understood that these supplementary materials are unfinished. However, we are content for the IBI to peruse them at this point if it so wishes. This is

[redacted]

> particularly in relation to the evidence given by its key witness of November 4th and 5th, 2020, which we strongly objected to, wherein our family reputation was openly besmirched (regardless of redactions), and which distressingly appears, currently, as the most visible written and video materials on the first locatable page of the IBI's online evidence pages, as has been the case for several days now. Yet our balancing evidence, first submitted to the IBI in July 2019, formatted in October 2019, and signed by us in March 2020, is nowhere to be seen.
>
> Mrs A Anakin, Mr G Murphy
>
> -
>
> N.B.:
>
> Regarding the enclosed "Document Extracts" PDF, the numbered sequencing relating to "Part Two" of our evidence, covering the period from September 5th, 1994, commences from document no. 254, which is found at PDF page 104.
>
> Also, the password for the "Document Extracts" PDF is still as per that set by the IBI in October 2019.
>
> ENDS.
>
> ENCL.

[redacted]

[redacted]

From: Gregory Murphy [redacted]
Subject: Re: Response to your recent correspondence
Date: 11 December 2020 at 17[redacted]3[redacted]0
To: Sarah Westoby [redacted]

Dear Sarah,

Thank you for your response and assurance of further advice.

To singularly answer your query about our signatures.

We sent these, with a hand-written covering note, by (at least) fist-class recorded delivery at the Walton Vale, Liverpool, Post Office branch on the morning of March 4th, 2020.

This was sent directly to the Inquiry at Fleetbank House (we were still under the impression at that time that fluid communications between ourselves and the Inquiry were not an issue). We made sure to do so at that specific point purely in view of the looming threats and rumours of lockdown, which none of us quite understood the implications of at that stage.

When we say that we sent the packet "at least" as recorded delivery, we only use the caveat because we may actually have sent the envelope as registered mail, but cannot be sure. It was certainly one of those additional postal services, though.

We will see if we can find the receipt over this weekend, but fear we no longer have it.

Nevertheless, even if the packet was only sent as recorded delivery, we would expect that somebody would have needed to sign for the envelope on March 5th, 2020.

It was simply two sheets of paper: the printed last page of our evidence, with our three signatures; and a covering note listing our three "WITN" identification numbers.

[redacted] [redacted]

Yours sincerely,

Mrs A Anakin, Mr G Murphy

On 11 December 2020 at 15[redacted]9, Sarah Westoby <[redacted]> wrote:

> Dear Mr Murphy,
>
> I hope this email finds you and your family well.
>
> I have now had an opportunity to review all of the recent correspondence, including your attachment to the Inquiry of 15th November 2020. I was concerned to note that your email of 15th November, though clearly cc'd to me, never reached me. I have explored this with our IT department here and understand it is because it was diverted to a junk folder. I am sorry this happened, but thankfully the Inquiry alerted me to this and forwarded me the missing email. IT have now changed the settings here so this should not happen again.
>
> I am sorry it has taken me so long to come back to you but, as you know, I have been attending Inquiry hearings recently and wanted to ensure I had read everything before responding.
>
> I would like to try to understand the situation with your Part 1 statement if possible. I note from my file that I sent the email below to you in October last year, with the statements for you and your family to sign. The Inquiry team have confirmed to me that they have not received your signed statements, yet I note your email of 15th November 2020, and subsequent email of 26th November, mention you signed the statements in March 2020 and submitted them. Can you please confirm how you submitted the signed statements to the Inquiry and to whom? I have no record of receiving your signed statements here. If you can tell me who they were sent to I can follow this up with the Inquiry to find out when Part 1 of your statement is likely to be published.
>
> Please rest assured there is no formal Inquiry deadline for submission of statements and our team here continue to work on behalf of our clients drafting and submitting statements and will

[redacted]

continue to do so until they are all complete. Therefore if you need to submit Part 1 now there would be no problem at all in doing so and I can do this on your family's behalf.

I have also reviewed your emails of 13th, 15th, 24th, and 26th November (and the attachment to your email of 15th November regarding your future engagement (or not) with the Inquiry). I would like to reflect on the issues you have raised carefully, and also discuss them with Emma, so am going to do so next week. I am afraid that our commitments are such that we cannot discuss this until the latter part of next week, but once I have done so I will update you and hopefully be in a position to provide you with our advice, which I note from your email correspondence that you have requested.

To reassure you in one respect (I see from your email of 26th November that you note the Inquiry could have sent a response via Leigh Day over the last 11 days), I can confirm that the Inquiry have contacted us since your email of 15th and I set this out in my email of 26th November. Please therefore at least be reassured in this respect that the Inquiry have responded to you via Leigh Day.

I look forward to hearing from you regarding the submission of Part 1, and will come back to you once I have discussed things further with Emma.

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones
Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB
[redacted]

From: Sarah Westoby
Sent: 16 October 2019 15:30
To: 'g[redacted] <gregmurph [redacted]>
Subject: (00186383/1) - response from Inquiry on witness statements

Dear Mr Murphy,

I have now heard back from the Inquiry team: they apologise for the delay in coming back to you, and I do too as I had heard last week but have been out of the office attending Inquiry hearings during the second half of last week.

[redacted]

[redacted]

The Inquiry have confirmed they have finished reviewing the draft statement you provided to them. They have made some changes to the initial draft, most of which have been made to ensure the style is consistent with a typical statement submitted to the Inquiry.

As you will be submitting a statement together as a family, the Inquiry team has decided to allocate you all with the same witness number as follows, Gregory Murphy (W1944(1)), Maureen Murphy (W1944(2)), Anne Anakin (W1944(3)).

The Inquiry team has split the draft statement into three distinct documents (all attached):

1. W1944001 - Written statement of Gregory Murphy, Maureen Murphy and Anne Anakin;
2. W1944002 - Document extracts (i.e. quotes referred to in initial draft); and
3. W1944003 - Chronology of events.

The Inquiry team's view is that the attached documents create an easy to follow structure and maintain the accuracy of the first draft prepared by you and your family. They consider this will also assist you in preparing Part 2 of you statement, which would then be labelled W1944004 (with further document extracts included as 005 and a chronology at 006, if you wish to provide that information).

Your question to me several weeks ago now when we first spoke about this process for submitting your witness statement was whether you could liaise directly with the Inquiry, and you asked whether you could sign the document provided to you by the Inquiry team at that stage. This is their response so, if you are content with this version of the statement, you would be able to sign and return this version (though, as you will see, there are some gaps to fill in, such as your dates of birth).

I will text you the password to access the attachments.

Let me know whether you would like to send the signed version to me to submit, or whether you prefer to liaise with the Inquiry direct.

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones
Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB
[redacted]
[redacted]

[redacted] [redacted]

From: Sarah Westoby [redacted]
Subject: RE: [EXTERNAL] Re: (00186383/1) - communications with the Inquiry and questions for Prof Hay
Date: 4 December 2020 at 17[redacted]5[redacted]2
To: Gregory Murphy g[redacted]

Dear Mr Murphy,

I am writing just to let you know that I had hoped to review things fully by the end of this week and come back to you. However, I have also been attending this week's hearings of the Scottish evidence of the Inquiry (remotely). Today's hearing overran and has only just finished. I will therefore turn to this next week (I return to the office on Tuesday), and come back to you as soon as I can.

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones

Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB

Leigh Day

[redacted]

[redacted]

From: Gregory Murphy <g[redacted]
Sent: 26 November 2020 18[redacted]5
To: Sarah Westoby <[redacted]k>
Subject: Re: [EXTERNAL] Re: (00186383/1) - communications with the Inquiry and questions for Prof Hay

Dear Sarah,

Thank you for clarifying matters.

Just a brief note ahead of you considering the various materials more fully.

The question is not strictly whether we would wish to re-engage with the Inquiry (and by that we mean the IBI team itself and the process) but rather whether the Inquiry would restore enough trust for us to ever do so. I am sure that after you review our materials, that you would conclude that we are of the view that, at the very least, we deserve a courtesy explanation for the Inquiry's actions and inactions towards us since August 13th. We're not so naive as to ever expect an apology; nor are we needy enough. The realisation that the Inquiry team has used the fact that we are a Leigh Day client as a reason for not bothering to contact us since November 15th (save a first-base courtesy, receipt message from the Engagement Team) frankly doesn't surprise us. For they could have sent a response via Leigh Day (even as a holding message) at any point over the last 11 days. They chose not to do so and have implicitly confirmed, by reading between the lines of your email, that

[redacted]

they had no intention of doing so anyway. Your contact with them seems merely to have triggered naught more than a platitude: i.e they're there if we wish to reach out to them, not the other way around.

The irony of all this, of course, is that it was the Inquiry's ill-considered, and frankly ill-tempered, response to our August submission, sent via yourselves, that finally eroded our faith in its process (though as we make clear in our submission of November 15th, we already suspected that relations had changed for the worse given the unjust measures placed on us on August 13th, completely out-of-the-blue - and we suspect we know who caused this). The fact that we then didn't even merit a courtesy forewarning from the Inquiry ahead of the evidence submitted by our father's former haematologist on November 4th and 5th essentially told us all that we needed to know. It seems to be pretty clear to us that it simply hasn't dawned on the Inquiry team as to just how bruising it was for us to endure our reputations being besmirched in the way that they were.

And of course, our Part One evidence still hasn't seen the light of day, almost nine months after we supplied our final signatures, and some 18 after we first submitted it.

Yet the Inquiry wonders whether we wish to "re-engage"?

Thank you, though, and sincerely, for your diligence in this matter.

Genuinely no reply required.

Yours sincerely,

[redacted]

Mrs A Anakin, Mr G Murphy

On 26 November 2020 at 16[redacted]8, Sarah Westoby <[redacted]> wrote:

> Dear Mr Murphy,
>
> Thank you for your email below. I am emailing to acknowledge safe receipt.
>
> I am afraid I had not received your email of 15 November, however the Inquiry have today forwarded it to me, as I can now see that I was cc'd to it. I do not know why I did not receive the email on 15th November, and am making enquiries of our IT department here to try to understand how this has happened (and to ensure it does not happen again).
>
> The Inquiry team note that you remain a client of Leigh Day and that would be why they have not come back to you directly in relation to your email of 15th. They do however note that your family is disillusioned following your engagement with the Inquiry, and they are offering to provide what support they can if you would wish to re-engage.
>
> I am due to be out of the office tomorrow and Monday, returning on Tuesday, when I will be remotely attending the first week of the Scottish evidence for the Inquiry. I will endeavour to consider your email below in detail next week, together with your email of 15 th November and the attachments also, and then come back to you more fully.

h[redacted]

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones

[redacted]

From: Gregory Murphy <[redacted]
Sent: 24 November 2020 14[redacted]6
To: Sarah Westoby <S[redacted]
Subject: Re: [EXTERNAL] Re: (00186383/1) - communications with the Inquiry and questions for Prof Hay

Dear Sarah,

Thank you for your message.

> Beyond the decision that we communicated in full on November 15th, there's realistically very little more that we can add. Especially given the Inquiry's non-response.
>
> We rather left the ball in the Inquiry's court - yet the subsequent silence (apart from a courtesy email from the Engagement Team) has been quite telling.
>
> Whilst we realise that the Inquiry has been very busy since November 15th, we genuinely didn't anticipate a response in any case.
>
> It has told us all that we really needed to know but, in all honesty, that we'd all but intuited anyway.
>
> So be it.
>
> Accordingly, our decision remains as per our communicated statement: (i.e. "We wish to communicate our feelings, convictions and stance concerning our intention to curtail future proactivity with the Infected Blood Inquiry (IBI). This does not preclude us responding reactively, should that ever be required. We await advice in that regard...As said, our decision is a reluctant one. Very. And we stand to be re-convinced otherwise. Failing any such re-assurances, though, we intend to simply remain as a default client of Leigh Day but having all but detached ourselves from the IBI.)
>
> We would, of course, appreciate continued receipt of the Leigh Day emails to at least keep abreast of progress. However, other than eventually presenting the

> final part of our evidence, it is quite distressing to finally conclude that for us the Inquiry is essentially over. Our trust and faith in its process, even its basic courtesies, has long gone; in reality on August 13th.
>
> In anticipation, then, that our communications will now be all but over (as said, apart from the very last submission of our evidence, for completist purposes; we must assume that the Inquiry would welcome it), then we thank you for all of your assistance over the last few years; although please do not hesitate to contact us if needed.
>
> Sincerely,
>
> Mrs A. Anakin, Mr G Murphy
>
> On 23 November 2020 at 15[redacted]0, Sarah Westoby <[redacted]> wrote:
>
>> Dear Mr Murphy,
>>
>> I just wanted to let you know that I had safely received your email below. I am sorry that the hearings have been so difficult for you and your family.
>>
>> I look forward to hearing from you when you are ready to communicate your decision.
>>
>> With best wishes,

[redacted] [redacted]

Sarah

Sarah Westoby, Solicitor to Emma Jones

[redacted]

From: Gregory Murphy <[redacted]
Sent: 13 November 2020 09[redacted]2
To: Sarah Westoby <S[redacted]>
Subject: Re: [EXTERNAL] Re: (00186383/1) - communications with the Inquiry and questions for Prof Hay

ATTENTION:THIS EMAIL ORIGINATED FROM OUTSIDE THE FIRM. **DO NOT** OPEN ATTACHMENTS OR CLICK ON ANY LINKS. **DO NOT** FORWARD THE EMAIL INTERNALLY UNLESS YOU KNOW THE SENDER

Dear Sarah,

Thank you for your reply.

This is just a brief courtesy update to inform you that we are very close to submitting our conclusion about how we intend to communicate and interact

[redacted]

[redacted] [redacted]

> > with the Inquiry process from here on in; if at all.
> >
> > We expect to be able to supply this, and accompanying rationale, at the latest during this weekend.
> >
> > Our decision will necessarily reflect our belief that the evidence hearings last week, and attendant publication of testimonies, concerning our father's former haematologist, have completely hung us out to dry with our personal reputations battered without any challenge whatsoever. We have suspected since August that a tone of negativity had been turned agin us by the Inquiry process (as has been proved severalfold) and accordingly expected a very trying experience last week (even if simply being in the virtual presence of that man). We did not, though, expect things to be quite as bad as they proved.
> >
> > At the risk of engaging in "low grade guerrilla war", as per the medic in question, we would say at this point that the unfolding process of last week proved two things at the very least: that we were right to wait until after the medic in question had provided his evidence before submitting our conclusion about our future communications and interactions; also the fact that we even knew to do so was testimony to our well worn experience both of him and his circuitous methods, and of the bruising we have suffered over the decades, particularly at the hands of the General Medical Council and those overseeing the so-called Archer Inquiry, that has sharpened our instincts to a level that only we would ever know.
> >
> > If you could, though, in the interim, let the Inquiry's so-called "Engagement Team" know that our mother does not "berate" anybody (as per the medic in question; a slur that we can quite literally disprove, through documentary evidence that we possess, concerning the specific allegation in question that he has made). Moreover, she simply does not possess the animal ability to do

[redacted]

> > so even were she ever justified in such actions. Rather, she is a very timid and deeply hurt individual. Thankfully, as a result of her recent complete detachment from the Inquiry processes (her instincts are arguably sharper than ours), she is completely oblivious as to what has now been published in the public domain about her (however much redacted; our case is a well known one in haemophiliac circles).
> >
> > We thank you for your assistance and forbearance with us over the past several weeks of glue and assure you that final clarity of our, admittedly very guarded, position will be forthcoming very shortly.
> >
> > Mrs A Anakin, Mr G Murphy
> >
> > On 3 November 2020 at 14[redacted]3, Sarah Westoby <[redacted]
> > [redacted]
> >
> > > Dear Mr Murphy,
> > >
> > > Thank you very much for your considered email. I am sorry to hear how this week's hearings is likely to impact on your family.
> > >
> > > I am also sorry you did not get our email requesting questions for Prof Hay. I have checked with our team here and understand this was sent out on Monday 26th October 2020. If you are having problems receiving such

emails please do let me know and I will check here to see if we need to amend anything.

We will send your questions for Dr Hay below to the Inquiry team in time for Wednesday and Thursday's hearings. If you want to send us any other questions you have for Dr Hay before 10am tomorrow I will ensure they get to the Inquiry team.

I also note your decision-making process in relation to who you would like to liaise with in relation to the Inquiry going forward (the Inquiry team direct, or Leigh Day). I await your decision on this once this week's hearings have concluded.

In relation to publication of core participants' statements, etc on the Inquiry website, please note that this is something the Inquiry is continuing to work on but there is some delay in publication of statements as there is a very large number to work through. The Inquiry continue to work on this and we will notify you as and when we are told statements are due for publication.

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones

[redacted]

Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB

[redacted]

From: Gregory Murphy <[redacted]
Sent: 02 November 2020 16[redacted]2
To: Sarah Westoby <[redacted]>
Subject: Re: [EXTERNAL] Re: (00186383/1) - communications with the Inquiry

ATTENTION:THIS EMAIL ORIGINATED FROM OUTSIDE THE FIRM. **DO NOT** OPEN ATTACHMENTS OR CLICK ON ANY LINKS. **DO NOT** FORWARD THE EMAIL INTERNALLY UNLESS YOU KNOW THE SENDER

Dear Sarah,

Thank you for your two replies.

We will reply more definitively after my late father's haematologist has given his evidence later this week (as still scheduled for Wednesday and Thursday), when we may (emphasis) finally be able to answer your question. However, we doubt it.

[redacted]

[redacted] [redacted]

-

Wednesday and Thursday are going to be very hard for us (even moreso knowing that our mother will not now even be aware of his planned appearance - having completely detached herself, probably sensibly, from the Inquiry's proceedings after so many decades of wasted campaigning).

If you are able to let the Inquiry team know (we must assume that they would still be interested in hearing about our welfare; though again, we have doubts, especially given the unforgivable tenor of its dismissively remote response to us on September 18th) just how daunting these two days are going to be for us and to bear in mind the sheer trial of endurance that it will be just to hear his voice and see his face again after so many decades. Especially as he'll likely tie the Inquiry team in knots. We really wonder whether they know what they're up against.

As an insight, we've actually experienced nightmares about his planned appearance (Mr Moore at the Inquiry probably won't recall a deeply anxious phone-call that we made to him, circa February 2019, back when we thought we could approach him directly that is,

[redacted]

> > > when we were anxious that the medic in question was going to be called as an expert, as per his involvement with Penrose; at least we've been spared that grandstanding aspect). We'd ask the Inquiry team (are we allowed to?) to consider that visceral reality; that we've actually experienced nightmares dreading the onset of November 4th and 5th. That's a measure of just how much a spectre his planned appearance has cast over us since we first learned of the autumn schedule (although we always knew the day would come sooner or later; and to think that whilst we were mentally steeling ourselves for his appearance and coming-to-terms with our mother's unexpected detachment from matters, the Inquiry team blithely thought it appropriate to excoriate us for our actions; just incredible).
> > >
> > > Our plan is to at least start watching the proceedings on Wednesday; whether we are emotionally able to continue to do so will be another matter; the experience will be somewhat akin to inviting him into our homes. If we find that we are not able to stomach several hours across two planned days in his dubious company no matter how remote - we've no idea how we're going to react to be honest – then we will have to wait until later in the week to read the transcripts of his no doubt meandering and ever disingenuous responses. It's been hard enough for us to adjust, since August, to digesting the recent disclosure revelations that we were made privy to concerning his and his legal team's disgraceful chicanery in 1997 regarding our failed medical negligence case against him (again, did the Inquiry team not even stop to consider this all-too-human likelihood before extending, via yourselves, its ill-thought-out response to our August submission? evidently not; still we trust that the whole body of evidence in question, concerning our father, at least ironically helps the anonymous third party in his/her pursuit of justice).

[redacted] [redacted]

> > > We have to say, though, that barring a knockout moment, we highly doubt that we will glean enough of an indication from the planned proceedings this week with that man to enable us to make an informed decision as to how best to proceed with our future involvement with the Inquiry. In any case, it's already clear to us that the Inquiry team that has little appreciation of our inconveniently nuanced and detailed evidence submissions thus far (and yet, for some reason, it was our father's case that was repeatedly used as the go-to case in both the House of Commons and Lords, and indeed the national press, in the late 1990s, as the matter of injustice concerning HCV infected haemophiliacs was finally being exposed; and for some other curious reason it was deemed that we should be the very first witnesses at the Archer Inquiry in 2007...regardless of the shocking treatment we actually did receive at Westminster on the day).
> > >
> > > You know, it seems deeply unfair that we now have to make such an either/or decision – especially after having discussed the matter at length with both yourselves and Mr Moore early in 2019, and seemingly reached an agreement satisfactory to all parties (and really, after over three decades of campaigning, long before any of the teams involved in the Inquiry had barely an inkling of the suffering that people like our father and mother have had to endure, would it genuinely be so procedurally improper for us to be afforded the communicative fluidity to be able to liaise with both Leigh Day and the Inquiry team as and when required, given the sheer complexities of our father's case?). Still, a decision we, apparently, must now be forced to make. So be it. We will. And, seemingly, all because we had the temerity to provide the Inquiry with a 15,000 word response to its completely out-of-the-blue request in August – which we dropped everything to comply with in one week flat and dared to complain about the timetabling – only to unwittingly prompt its corporate ire. Staggering.

[redacted]

[redacted] [redacted]

>>> Without wishing to pre-empt matters ahead of hearing from our late father's haematologist, we would say, though, that in any case we'll likely not choose to deal directly with the Inquiry from here on in (frankly, how could we now after that disgraceful lambasting?) even were we to retain an interest in proceedings. Basically, then, the only decision we would have to make, boiled down, would be: 1) whether to actively continue with Leigh Day and with eager interest in the Inquiry; 2) whether to continue with Leigh Day just purely on a default basis to see how the Inquiry pans out (and to be honest we already know the answer to that – there isn't a prayer that justice will ever be served); or 3) whether, after Thursday's draining inevitability, to completely cut our ties, as per our psychologically battered mother, with every aspect of the Inquiry (if so, our loss-cutting reasoning would be that we've already wasted almost three years of our lives in compiling and submitting evidence, so why risk adding a fourth and maybe a fifth?).
>>>
>>> The whole vexed situation that has come out of nowhere to beset us since August (when ironically we initially thought we finally had a breakthrough moment after years of hoping and after submitting Part One of our evidence; we really should have known better) has been intolerable; especially after decades of such similar let down experiences (not least at the Archer Inquiry; perhaps the fact that we've already adverted, in the first part of our probably wasted evidence, our intention to publicise certain realities about that dubious occasion in April 2007 is an inconvenient truth that the Inquiry wouldn't wish for us to expose? But we recall being assured in July 2018, in Liverpool, by the Inquiry team that there wouldn't be any 'sacred cows'; in fairness that was our term).
>>>
>>> Anyway, until (hopefully) later this week, then, we will hold off from adding further.

[redacted]

[redacted] [redacted]

Except to say in closing, three things:

1) We note that Part One of our evidence, first submitted in July 2019, still hasn't been published. Given the Inquiry's tone on September 18th, we have to say we're not really that surprised and we doubt that it ever will see the light of day;

2) We note that we've been afforded the right to submit questions ahead of all the witness appearances this autumn - but signally not regarding our late father's haematologist (though probably just as well; actually, maybe if the Inquiry team could ask him what he thinks an alpha-fetoprotein reading of 9280 might ever indicate in a Hepatitis C positive haemophiliac with cirrhosis of the liver diagnosed at least two years earlier! or whether he thought liver biopsies were suitable for determining the extent of liver disease in haemophiliacs circa, say, June 1992, the eighth of that month to be precise?). We wonder why not? Actually, we really, really don't, because we've got long and deeply jaded experience of that man, and can already see that he's being afforded different treatment to all other witnesses. Why aren't we surprised?

[redacted]

> > > 3) We note that the evidence file submitted to us in August, with plan to publish it on the 30th of that month, still hasn't appeared. We could say more, but frankly we're just drained and anyway it's going to be the proverbial week from hell for us.
> > >
> > > Yours sincerely,
> > >
> > > Mrs A. Anakin, Mr G Murphy
> > >
> > > On 8 October 2020 at 15[redacted]9, Sarah Westoby <[redacted]
> > >
> > > > Dear Mr Murphy,
> > > >
> > > > Further to our emails below I just wanted to get in touch to say that we note your holding response and look forward to hearing from you in due course with your instructions on whether you wish to continue to instruct Leigh Day or not.

[redacted] [redacted]

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones

Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB

[redacted]

From: Sarah Westoby
Sent: 18 September 2020 17[redacted]0
To: 'Gregory Murphy' <[redacted]
Subject: RE: [EXTERNAL] Re: (00186383/1) - communications with the Inquiry

Dear Mr Murphy,

Thank you for your email. I will consider what you have said below in detail but wanted to email to just let you know that it was not the Inquiry who delayed in responding. I am afraid I was on annual leave and that, as well as other work commitments, has contributed to the delay in responding to you.

[redacted]

My apologies for that.

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones

Leigh Day Priory House, 25 St John's Lane, London EC1M 4LB

[redacted]

From: Gregory Murphy <[redacted]
Sent: 18 September 2020 16[redacted]6
To: Sarah Westoby <[redacted]
Subject: [EXTERNAL] Re: (00186383/1) - communications with the Inquiry

ATTENTION:THIS EMAIL ORIGINATED FROM OUTSIDE THE FIRM. **DO NOT** OPEN ATTACHMENTS OR CLICK ON ANY LINKS. **DO NOT** FORWARD THE EMAIL INTERNALLY UNLESS YOU KNOW THE SENDER

Dear Sarah,

[redacted] [redacted]

Thank you for contacting us and for providing the Inquiry's very delayed response to us.

This is a courtesy, holding reply purely to state that it is probably wiser for us to first let our emotions subside, in the wake of reading the Inquiry's quite detached, and frankly disenfranchising proxy response. We would be grateful if you would, in turn, forward our first responses to them - as per the now desired protocol (despite our previous discussions with the Inquiry team about desired communication methods, even as early in the whole process as July 2018 in Liverpool).

We will now rather wait to see how the Inquiry intends to use the materials in question - that, after all, no matter how redacted, relate extensively and directly to our father and to us but not actually to our case; irony of all ironies - and then review how we wish to proceed in our dealing with both the Inquiry and yourselves. If at all.

For at this moment, we are quite minded - given our horrendous experiences with the Archer Inquiry in 2007, not to forget with the GMC in 2004 - to completely cut our losses and cease our further involvement overall. We really didn't deserve that cold, corporate-speak response from the Inquiry; and our worst fears, borne of bitter experience over several decades - would seem to be materialising. We had a feeling that even daring to criticise the Inquiry (as we did in our preamble) would backfire, and so it has been proved. They gave us just six or so days to provide a response to a "lengthy" (to mirror the Inquiry's description of our submission) document and yet forgot to communicate that they didn't actually require such an exercise in any case. Telepathy is not one of our skills. We dared to criticise the Archer Inquiry in 2007 and we were made to pay for it. This has all the hallmarks of deja vu for us. We note also that the Inquiry chose to

[redacted]

> > > > ignore the extra aspects of our submission on August 20th not least the progress of Part One of our evidence which, as stated, we provided (one page) signatures to just prior to lockdown.
> > > >
> > > > Of course we could say more, but it's probably prudent to let our feelings calm somewhat. However you can gather from the above that we are not best pleased with the Inquiry's tone.
> > > >
> > > > We will now watch with interest as to how the Inquiry uses our documentation.
> > > >
> > > > Yours sincerely,
> > > >
> > > > Mrs A. Anakin, Mr G Murphy
> > > >
> > > > On 18 September 2020 at 10[redacted]6, Sarah Westoby <[redacted]> wrote:
> > > >
> > > > > Dear Mr Murphy,
> > > > >
> > > > > I write further to recent correspondence.
> > > > >
> > > > > I am sorry to hear about the decline in your mother's well-being. I note your request for support via the psycho-social team of experts, however, these are expert witnesses to the Inquiry, rather than a support team for Inquiry witnesses. The Inquiry is funding a

confidential support service, run by a team from the British Red Cross and details can be found here: https://www.infectedbloodinquiry.org.uk/psychological-support-provided-inquiry

The Inquiry team has considered your document in relation to the GMC complaint and said as follows:

'The purpose of our email dated 10 August 2020, was to notify you of the upcoming disclosure of the GMC material and provide you with copies of the redacted material for brief review. Our intention was not to invite lengthy submissions, but rather to provide you with a notification as a courtesy and as an opportunity for Leigh Day to raise any pressing issues relating to the disclosure of the GMC material and the redactions contained therein.

The Inquiry's counsel team have reviewed and considered the GMC files in their entirety already, and we are only disclosing key aspects of the material. The redactions have been applied for consistency, as some of the complaint files relate to complainants who are not Inquiry witnesses.

Whilst we are grateful for the additional information provided by Mr Murphy and Mrs Anakin, their response is more appropriately reserved for inclusion within their witness statement.'

In terms of the GMC complaint, the Inquiry have confirmed that they will interpret your response as not raising any issues regarding the disclosure of the redacted GMC files.

[redacted] [redacted]

You will note that the Inquiry team have chosen to communicate the above to us, as your solicitors, rather than directly to you – asking us to communicate their response to you. I know from our previous discussions that you wish to communicate simultaneously with both Leigh Day and the Inquiry directly, to, as you have explained, 'always have the ability to deal as fluidly as possible with both parties'.

I have discussed this with Emma and our view is that, should you wish to continue to deal directly with the Inquiry, ensuring that they correspond directly with you, the best way forward would be for you to be a Core Participant without legal representation. This would mean no longer being represented by Leigh Day. Other CPs have had this discussion with us in the past and have chosen this route because one of the most important issues for them is to be able to have direct involvement with the Inquiry team, rather than having to go through the legal team.

If you continue to be represented by Leigh Day then it is most likely the Inquiry will not respond to you directly, but will instead choose to liaise through us. This is important because there are individuals who do not have legal representation and therefore have to communicate directly with the Inquiry team and so to ensure that the Inquiry team have sufficient time to communicate directly with those without legal representation, core participants with legal representation are asked to deal with/communicate through their legal team who can either deal with any issues arising or if that is not possible deal with the right individuals at the Inquiry.

I know from our previous discussions that this issue of

[redacted]

communication channels is extremely important to you as a family. I would be grateful if you would consider this and let me know how you wish to proceed.

With best wishes,

Sarah

Sarah Westoby, Solicitor to Emma Jones

[redacted]

[redacted]