Witness Name: Professor Charles Richard Morris Hay

Statement No.: WITN3289190

Exhibits: Nil

Dated: 14/6/2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR CHARLES RICHARD MORRIS HAY

I provide this statement in response to a notice under Rule 13 of the Inquiry Rules 2006 dated 22 August 2022 in relation to the criticisms of Witness W3205, dated February 2021 but sent to my legal representatives in late August 2022. I, Professor Charles Richard Morris Hay, will say as follows:

Section 1: Introduction

1. Professor Charles Richard Morris Hay MBChB MD FRCP FRCPath

Consultant Haematologist Manchester Royal Infirmary since December 1994.
Director Manchester Adults Haemophilia Comprehensive Care Centre since December 1994

Professor of Haemostasis and Thrombosis.

Senior Lecturer in Haematology Liverpool University and Director Liverpool Haemophilia Centre, Royal Liverpool Hospital 1987-1994.

Director UK National Haemophilia Database since 2002.

Member UK Haemophilia Centre Doctors Organisation (UKHCDO) Regional Committee from 1987 and then Advisory Committee since 2007 (when the committee name changed).

Vice Chairman UKHCDO 1997 to 2005.

Chairman UKHCDO 2005-11.

I have already provided a copy of my Curriculum Vitae to the Inquiry.

Section 2: Responses to criticism of Witness W3205

2.The Manchester Haemophilia Comprehensive Care Centre (Adults) is based in Manchester Royal Infirmary. This was the third largest haemophilia Centre in the United Kingdom. It is now the second largest with >2500 patients with bleeding disorders registered. When I arrived in December 1994, I was the only consultant specialising in adult Thrombosis and Haemostasis in the North-West Region, assisted by a part-time clinical assistant, Dr Monica Bolton. We now have four consultants with this specialism. In 1994, we had three Haemophilia Nurses, one of whom also did counselling and went into the community. There were no clinical research staff. There were no joint clinics and no formal liaison with any other supporting specialism or profession allied to medicine, such as physiotherapy. All the follow-up clinics were conducted in the Haemophilia Centre without any junior staff support. There was no internal training rotation for junior staff so they spent all their time treating leukaemia. I was on call 1:1 i.e. 365 days a year except when away or on holiday.

3. In the first year, I introduced an internal training rotation for junior staff so that we had a registrar attached to thrombosis and haemostasis most of the time. I introduced weekly multidisciplinary meetings and arranged for Physiotherapy input for our patients. I rapidly established joint clinics for Orthopaedics and subsequently joint HIV clinics and joint obstetric clinics and later joint adolescent clinics with the paediatric service. Liaison with Hepatology was close throughout this period but not formalised around a clinic. As we acquired more consultants specialising in Thrombosis and Haemostasis, first in 1999 and then in 2003 and in 2018, the patients were reallocated among the consultants.

4. Witness W3205 does not appear not critical of me, as far as I can determine, though my attention has been directed by the Inquiry to paragraphs 20 and 21. In those paragraphs the witness quotes from my letter to his GP from January 1995. This was my account of my first encounter with the witness, shortly after I took up post, in which I evaluated his past treatment and his virology and biochemistry results and reported those to the GP. I described how the patient's liver function tests had been consistently abnormal from 1988 and I also noted that he was HCV PCR positive.

5. The witness has taken this, correctly, as meaning that there was evidence of HCV from 1988 and most probably he would have been infected much earlier. He implies criticism of my predecessors in not telling him sooner that he had HCV and not counselling him
about potential spread to his wife. In fact, up to the advent of reliable HCV antibody testing in 1992, he would have been classed as having non A non B hepatitis. This should have been discussed with him by my predecessors.

6. The HCV virus was not isolated until 1989 and unreliable testing came two years later. Information about the risk of transmission to family members came later still. Once the virus had been isolated and specific testing introduced, knowledge of HCV expanded rapidly.

Section 3: Other Issues

7. None

Statement of Truth

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

Signed GRO-C

Dated 14/6/2023