Witness Name: Dr Peter May
Statement No.: WITN3177001
Exhibits: WITN3177002
Dated: 13 March 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR PETER GEORGE MAY

I, Dr Peter George May of GRO-C (date of birth: GRO-C 1945) will say as follows: -

Section 1: Introduction

1. I qualified in 1973, when I obtained Membership of the Royal College of Surgeons and the Licenciate of the Royal College of Physicians (MRCS LRCP). I became a Member of the Royal College of General Practitioners (MRCGP) in 1981.

2. Having completed my hospital training in Northallerton in 1973-74 I then became a trainee in General Practice within the Southampton Vocational Training Scheme in 1977-1980. Between 1980 and 2006, I was a General Practitioner and partner at the Shirley Healthcare Centre in Southampton. In 1997 the Practice comprised 6 equal partners – Drs Carol Clouter, Simon Fraser, John Nightingale, Peter Short, Robert Walton, and myself. The Practice had a list size of approximately 10,000 patients and operated a personal lists system. There were approximately 1,600 patients on my personal list.

3. I retired in 2006 and have not practised medicine since then in any capacity. I am now aged 74.

Section 2: Response to Criticisms

4. I have had the opportunity to review the Inquiry's Rule 9 letter of 3 May 2019, together with the documents selected for disclosure, comprising Witness 1962's first written statement of 19 February 2019, and her exhibits WITN1962 5-10 and 12-13. I have also had the opportunity of reading the transcript of the oral evidence given to the Inquiry by Witness 1962 and her daughter on 6 June 2019.

5. I am aware that attempts have been made to locate Mr Le Bourn's general practice medical records for the years 1997 and 1998, given their potential relevance to the concerns raised by Witness 1962. The Shirley Health Partnership still exists, but the only records that it has been able to locate in relation to Mr Le Bourn during the relevant period, consist of a 2 page printout from the patient's computerised records, a copy of which I produce as exhibit WITN3177002 This contains very little information, because at the time only basic details were entered in the computer records such, as height, weight, blood pressure, smoking, alcohol intake and prescriptions. Consultation details including the presenting condition, diagnosis, and treatment were recorded on paper records, and all incoming correspondence and copies of outgoing correspondence were stored manually.

6. All General Practice records are expected to be retained for 10 years after a patient's death. Since Mr Le Bourn passed away in June 2013, his General Practice records should still be in existence. However, I understand that the Inquiry has approached Primary Care Support England (PCSE), a division of NHS England, who have confirmed that no other records have been located. I also understand that notwithstanding paragraph 90 of Witness 1962's statement, neither she nor her solicitors hold any copy records other than those that have been exhibited to her statement.

7. Consequently in responding to the Rule 9 letter of 3 May 2019, I am necessarily dependent upon my limited direct recollection of events some 23 years ago, my standard practice at the time, and the incomplete documentation that has been made available. Should additional contemporaneous records or correspondence become available, I reserve the right to provide a further statement revising as necessary the observations that follow below.

8. I have some recollection of Mr Le Bourn, who had been a patient of the Practice and on my personal list for some years prior to the events in question. He was a Social Worker by profession and an anxious patient with significant medical problems. He wore a prosthetic limb which caused frequent chaffing, and had chronic obstructive pulmonary disease and severe emphysema, as a result of many years of heavy smoking.

9. As a result of his respiratory illnesses Mr Le Bourn was under the care of a Consultant Chest Physician, Dr Richard Godfrey, at the Royal Southampton Hospital. Dr Godfrey had referred Mr Le Bourn to the Transplant Unit at the Papworth Hospital in order to assess Mr Le Bourn's suitability for a lung transplant. Consequently, the

referral to Papworth Hospital had come not from me, but from Dr Godfrey. Neither I nor the Practice was involved in the referral process.

10. Witness 1962 has produced as exhibit WITN1962005, a letter dated 4 November 1997 from Papworth Hospital NHS Trust to me and copied to Dr Godfrey. It confirmed that the transplant assessment virology screen had revealed that he was "*positive for Hepatitis C antibody*". The letter invited me to bring this to the patient's attention and to provide the necessary counselling. It did not suggest the initiation of any treatment or onward referral for treatment.

11. Reference to the General Practice computerised records WITN3177002 confirms that I saw Mr Le Bourn for a routine consultation on 6 November 1997, when I checked his weight and prescribed an inhaler. This was a routine recall, and for all practical purposes identical to the consultation I had with Mr Le Bourn on 19 May 1997. I am confident that the consultation on 6 November 1997 was not connected with the correspondence from the Papworth Hospital dated 4 November. That letter would have been sent by post, and would not have come to my attention until after my consultation with Mr Le Bourn on 6 November 1997.

12. It appears from the computerised record, that uncharacteristically, Mr Le Bourn did not then attend any doctor at the Practice until his consultation with me on 26 October 1998. I do not believe I had any contact with him in the interim, but cannot be certain in the absence of the clinical records.

13. In 1997 I knew very little about the Hepatitis C virus or its causes, diagnosis, management and treatment, and I believe most if not all other General Practitioners would have been in the same position at that time. The virus had only been definitively identified in 1991. Even Hepatologists had limited knowledge of the virus (which was formerly referred to as non-A non-B Hepatitis) at that time.

14. Over the following 20 years until my retirement, medical knowledge about Hepatitis C grew enormously, but in 1997 tests for Hepatitis C for patients with mild and unexplained abnormalities in their liver function tests (previously known as transaminitis) had not begun. As far as I recall, Mr Le Bourn was my first patient to be diagnosed with Hepatitis C, and I can remember no subsequent diagnoses. It was therefore a novel condition and remained comparatively rare.

15. The letter from the Papworth Hospital dated 4 November 1997 came out of the blue. It was copied to Dr Godfrey, the respiratory physician at the Royal Southampton Hospital, as he had made the referral. I had not been involved in Mr Le Bourn's

referral. The Papworth Hospital had initiated the test, but did not send me any briefing about the implications of the diagnosis, or the counselling that was required. Furthermore their letter did not convey any sense of urgency. In fact with the benefit of hindsight, I note that the letter of 4 November 1997 refers to Mr Le Bourn having tested positive for the Hepatitis C *antibody*. This suggests past contact with the Hepatitis C virus and was not evidence of current disease, which instead would be indicated by increasingly abnormal liver enzyme tests. Mr Le Bourn had therefore developed immunity and there was no need to effect treatment on the basis of the information at that stage. Ongoing management would require nothing more than periodic liver enzyme tests. Had his liver enzyme tests been significantly abnormal, I would have then referred him to a hepatologist.

16. It is impossible to say with certainty whether upon receipt of the letter from Papworth Hospital dated 4 November, I decided to inform Mr Le Bourn of the Hepatitis C test result upon his next attendance, (in accordance with my usual practice if immediate action was unnecessary), or whether the correspondence was inadvertently missed and not seen by me until I reviewed Mr Le Bourn's notes when he next attended on 26 October 1998. I believe the former scenario to be more likely.

17. My lack of experience in the management of Hepatitis C, or counselling of patients newly diagnosed with the condition, was only part of my difficulty. Mr Le Bourn was an anxious patient with a serious and complex respiratory condition. I realised that the positive test result could have ramifications for his suitability for the contemplated lung transplant, in that the immunosuppressant drugs given to maximise the prognosis for the transplant could potentially result in the Hepatitis C virus becoming active and damaging the patient's liver.

18. I realised that upon being informed of the diagnosis Mr Le Bourn would have many questions which I would be unable to answer, and that the limits of my knowledge of the condition would be quickly exceeded. I knew the patient well enough to appreciate that if he was deemed unsuitable for transplant as a result of this, he would take the news very badly.

19. The absence of reference materials also played a part. I had no literature concerning the causes, diagnosis and management of Hepatitis C at that time, and these events pre-dated the age of the internet, enabling novel or emerging conditions to be researched relatively easily. Unusual or difficult conditions would be discussed between the partners at our weekly clinical meetings, and would usually result in a referral to an appropriate consultant. If I had discussed Mr Le Bourn's case with my

colleagues, it is likely that I would have made a note in his records, in accordance with my usual practice.

20. In any event, it appears that I decide rather than to call Mr Le Bourn into the Practice to discuss the test result, I would deal with it when he next attended, since I knew him to be a regular attender. I may well have made a note to that effect in order to remind myself upon his next presentation.

21. With hindsight I accept that this was a bad decision which I very much regret, as Mr Le Bourn did not in fact attend again for nearly a year. He had not been informed by the Papworth Hospital that there was an outstanding blood test result, or that he should arrange to see his General Practitioner to discuss it. Without access to the medical records, I do not know whether in the intervening period he had any further consultations with Dr Godfrey, who was also copied into the Papworth letter of 4 November 1997, but if so, it can inferred from the events that followed, that Dr Godfrey also did not inform Mr Le Bourn of the positive test result.

22. In retrospect I should have asked Mr Le Bourn to make an appointment, and sought guidance from the Transplant Unit at that stage in relation to the causes, prognosis and management of Hepatitis C.

23. My understanding at the time was that there was a range of possible causes for Hepatitis C, which would presumably necessitate taking a detailed sexual history, as well as exploring drug and alcohol use. I realised that I would need much more information about Hepatitis C and its treatment options, which he would undoubtedly ask about, in order to conduct any counselling as to the risks and consequences. I very much doubt that I would have realised that his infection was most likely the result of a blood transfusion many years earlier. His road traffic accident and the subsequent amputation of his leg had long preceded his joining the practice list, and in all probability I was unaware that he had undergone a blood transfusion. Consequently the source of the infection would have been unknown at that time.

24. When Mr Le Bourn next attended on 26 October 1998, as my letter to Dr Godfrey of 2 November 1998 describes, the patient was in a positive frame of mind. It clearly became apparent to me during or immediately after the consultation, that he had remained unaware of the Hepatitis C result, presumably as a consequence of not having attended either me, Dr Godfrey, or the Papworth Transplant Unit in the interim. I fully accept that I should have informed him at that stage, but I was reluctant to do so given my continued limited knowledge of the condition. I therefore decided not to raise it with him until I had either obtained further advice, or Mr Le

Bourn had been advised and counselled appropriately by someone else – hence my letter to Dr Godfrey dated 5 November 1998. In short I could see no benefit in informing him of the result, unless I was at the same time able to offer counselling advice as to the causes and management of the condition and its implications, if any, for his other medical problems and also for the contemplated lung transplant.

25. My letter to Dr Godfrey of 2 November 1998 is therefore an accurate summary of my position at that time. In that letter I concede that because Mr Le Bourn had not needed to attend the Practice for an uncharacteristically long time, there had been a delay in informing him of the diagnosis. Moreover, I was clearly concerned that in imparting that diagnosis would undermine the positive frame of mind of a generally very fragile patient. I made clear that I considered that I was at a disadvantage as a result of my lack of knowledge of Hepatitis C.

26. I agree that the request to "pass the buck" could have been better phrased. Nevertheless, that is what I considered I was doing at the time, because managing Mr Le Bourn's diagnosis was not within my expertise. There is a recognition in my letter that Mr Le Bourn needed to be informed of his diagnosis and an acceptance that if Dr Godfrey felt unable to do so at his forthcoming appointment with the patient in January 1999, then I would do so, hopefully by that stage being in a position to offer constructive advice and counselling, or referral.

27. Dr Godfrey's letter to Dr Sue O'Connell in the Virology Department at the Public Health Laboratory of 8 November 1998 (WITN1962007), and his reply to me of the same date (WITN1962008), are both of some significance, since it is clear that Dr Godfrey also felt unqualified to offer Mr Le Bourn counselling and advice regarding the Hepatitis C result. He too observes that Mr Le Bourn was an extremely anxious patient, and expressed his reluctance to raise further fears in the patient's mind before having obtained appropriate advice from a virology specialist.

28. Dr O'Connell's advice is then set out in her letter to Dr Godfrey of 7 December 1998 (WITN1962009) but it seems that before that advice could be relayed by Dr Godfrey to Mr Le Bourn, Witness 1962 learned of the test result directly from the Papworth Hospital, as described in paragraph 9 of Witness 1962's statement.

29. Although I have no direct recollection (and there is no written record available) of the telephone conversation, Witness 1962 describes in paragraph 15 of her statement, my failure to provide Mr Le Bourn with any further information as to Hepatitis C, how it was contracted, or the options for treatment, of which Witness 1962 complains,

reflected my lack of knowledge at that time, which I was attempting to rectify by seeking appropriate advice before discussing the result with my patient.

30. Mr Le Bourn and his family subsequently transferred to another Practice, in Lyndhurst.

31. In 1997 very little was known about the transmission of Hepatitis C and the extent to which it differed from the transmission of Hepatitis A (airborne) and Hepatitis B (blood- borne and through sexual contact). I therefore believe it was reasonable to seek advice from a specialist before counselling the patient and his wife regarding transmission risk. All we knew at that stage was that Mr Le Bourn had tested positive for Hepatitis C antibodies, and that consequently, as Dr Godfrey's letter to Mr Le Bourn of 8 February 1999 (WITN19620010) confirms, his condition was not in need of urgent treatment. Only later did it become clear that Hepatitis C is extremely difficult to transmit, sexually or otherwise, and Mr Le Bourn did not infect either his partner or his daughter.

32. In summary therefore the difficulties I faced in November 1998 were threefold, and I think all contributed to the delay in informing Mr Le Bourn of his test result:

    1. Lack of specific knowledge of Hepatitis C and an inability to explain its ramifications to the patient.

    2. An easily distressed and understandably anxious patient.

    3. Mr Le Bourn's serious and complex lung disease and contemplated lung transplant which would have entailed immunosuppressive therapy. These difficult issues were being handled by appropriate specialists. The team at Papworth had discovered the presence of Hepatitis C antibodies and had access to hepatologists and viroiogists at Addenbrooke's or on referral back to the Royal Southampton Hospital, for the purposes of work up for the contemplated lung transplantation. It was not in line with usual practice at that time simply to refer back to the General Practitioner to deal with the diagnosis.

33. I regret that I was not in a position to provide more information and advice to Mr Le Bourn at the time and I am truly sorry for the delay in conveying the test result to him, but I do not believe this adversely affected his condition or treatment.

Statement of Truth

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

Signed GRO-C

Dr Peter George May

Dated 13th March 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
1997 - 1999	Extract from Mr Le Bourn's electronic GP records (Shirley Healthcare Centre)	WITN3177002