Witness Name: Professor Charles Richard Morris
Hay Statement No. WITN3289001
Exhibits: WITN3289002 - 005
Dated: 21st February 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DOCTOR CHARLES RICHARD MORRIS HAY

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 10 June 2019 in relation to the statement of Mr Sean Nevin and statements from his family members.

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
   Senior Lecturer in Haematology Liverpool University and Director Liverpool Haemophilia Centre, Royal Liverpool Hospital 1987-1994.
   Professor of Haemostasis and Thrombosis.
   Director UK National Haemophilia Database since 2002.
   Member UK Haemophilia Centre Doctors Organisation (UKHCDO) Regional Committee and then Advisory Committee since 2007.
   Vice Chairman UKHCDO 1997 to 2005.
   Chairman UKHCDO 2005-11.
   I attach my curriculum vitae as exhibit WITN3289002

2. In May of 1987, I took up post as Senior Lecturer in Haematology and Honorary Consultant Haematologists and Director of the Liverpool (Adults) Haemophilia Centre Based at what was then known as the Royal Liverpool Hospital. Although nominally only 6/11 of my sessions were clinical, I was the only specialist in Thrombosis and

Haemostasis (both for adults and paediatrics) in the Mersey region and serving North Wales. I also had responsibility for management and follow up of a third of all the Malignant and General Haematology coming into the Royal Liverpool Hospital including bone marrow transplantation. This situation continued until 1992, when I was finally able to give up malignant haematology. I was on-call one day in three for most of the time from 1987 until 1994. I left this post in December 2004 to take up post at Manchester Royal Infirmary. In the 25 years that have elapsed since then there has been no change in the number of support staff for Haemophilia but the consultant numbers have increased to four.

3. When I took up post in Liverpool in 1987, I found that there was no haemophilia centre as such. The patients would come to the Haematology laboratory if they had a bleed. There were no haemophilia nurse specialists, no physio input, no social worker and no joint clinics of any sort. Comprehensive haemophilia care had not been established in Liverpool in any meaningful sense. Furthermore, the block contract for haemophilia care made expansion of the service difficult and this had to be replaced by individual patient contracts and fees to provide the funding necessary to improve the service.

4. Additionally, the proportion of patients infected with HIV was above the national average and those patients were receptive and appreciative of attempts to improve their care on the one hand but harboured a good deal of anger having been informed of their HIV status by my predecessor by post rather than face to face and having been offered little or no psychological support prior to my arrival.

5. By degrees and as rapidly as possible over a period of about three years, I built up a Comprehensive Care Service, first establishing a weekly multidisciplinary Comprehensive Care Clinic with a Physio and then also a Haemophilia Nurse Specialist and then adding a social worker and a second Specialist Nurse and a multidisciplinary meeting which would include lab staff as well. We also established a Joint Orthopaedic Service and a close working relationship with Professor Ian Gilmour, Consultant Hepatologist, who did his clinic in the room next to my Multidisciplinary Haemophilia Clinic and was therefore very freely available for advice and to see patients as required.

6. This was the most difficult period following the advent of HIV. We were all, doctors and patients alike, learning about the natural history of this previously unknown

condition and treatment was evolving. The patients were struggling with uncertainty and increasing ill health. Treatment for HCV was in its infancy and not very effective for most patients. To start with, there was no treatment for either condition and then anti-retroviral drugs were slowly introduced and administered in maximum tolerated doses. This was only transiently and partially effective in arresting the progress of HIV and poorly tolerated. It was during this period that most of the patients with HIV died, either from AIDS or from liver failure. In 1995, triple therapy was introduced and HIV-related deaths reduced to a very small number and liver deaths also fell dramatically.

7. The entire team were very actively involved in offering this group as much support as we could. It is noteworthy, that when I left to take up the post in Manchester, almost 40 of my patients followed me and our Senior Haemophilia Nurse and Social Worker both resigned and took up posts in other areas because they were "burned out". This is a common phenomenon amongst carers of highly stressed patient groups requiring a lot of psychological support and especially where the staff get to know the patients and their families well.

8. Patients with HIV or serious liver disease would be reviewed once a quarter in clinic, every six months if they did not have these complications or had mild liver disease and more frequently as necessary. All patients were offered a drop-in service for acute problems or if they wanted to come in and discuss things more informally. When they came to clinic they would usually see me but would sometimes see the Senior Registrar. If a patient specifically requested to see the consultant and assuming I was present, then they would see me. If the registrar was not sure what to do they would ask me.

9. Patients with liver disease had their liver function tests (liver biochemistry including transaminases) conducted every six months from the late nineteen seventies and were investigated further for exposure to hepatitis B, A and C when the tests first became available. Hepatic ultrasound was conducted approximately every two years and sooner if something changed.

10. I was Mr Nevin's Haemophilia consultant between May 1987 and November 1994 at the Liverpool Centre, until I left to take up post in Manchester. Having not seen Mr Nevin for twenty five years, I have prepared this statement with the assistance of an

extract from his medical records covering the period 1981-94, which was provided to me by the Inquiry.

11. Mr Nevin has mild/moderate Haemophilia A with a Factor VIII level of 5%. As such, it had been necessary to treat him with Factor VIII concentrate on many occasions for spontaneous or traumatic bleeding or surgery.

12. Mr Nevin was first tested for Hepatitis C (HCV) on 1/4/92, shortly after the test became available (WITN3289003, WITN3289004 of notes extract provided). This test was positive with full confirmation on 12.07.1994. He would previously have been assumed to have non-A, non-B hepatitis, his liver function tests having been intermittently abnormal. His HCV positivity was confirmed on 31/3/93 and 12/7/94. I could find no written evidence that it was specifically discussed with him prior to 11/7/94. All his consultations at that time related to his recurrent painful haematuria, a problem which was very actively investigated and which led to repeated hospital visits and admissions and which was a major source of concern to him and to us.

13. Mr Nevin complains that his liver function tests and HCV were obtained without his consent. Specific consent would not normally have been obtained for such blood analyses and we would not expect consent to be withheld. Liver function tests and Hep A and B were routine tests in haemophilia patients and HCV testing would have been regarded as an extension of the investigation of all patients with a bleeding disorder who had been treated with blood products.

Section 2: Responses to criticism from the Nevin family

1. On 11/7/1994, Mr Nevin attended for routine review and saw Dr Angela McKernan, an experienced Senior Registrar, who shortly after that left to take up a post as Consultant Haematologist in Derby as Director of the Derby Haemophilia Centre.

2. I was not present at this review. I have investigated my whereabouts as best I can, despite which I have no idea where I was on that day 25 years ago. I was not in a committee meeting or scientific conference as far as I can determine. I no longer have my diary for that year. However, I can say that Mr Nevin's suggestion that I

deliberately absented myself so that I did not have to speak to him is certainly not the case. I would never have acted in that way. In the Centre we had a close clinical relationship with patients, as we saw them so frequently. Furthermore, I saw him at his very next consultation (see below).

3. Even had I been in the clinic on that day, Mr Nevin may still have seen another doctor unless he had specifically requested to see me, in which case I would have been happy to see him. Patients did not always see the consultant at every visit and he had seen a senior registrar rather than a consultant about 50% of the time.

4. On this occasion, he saw Dr McKernan. Also present was our senior Haemophilia Nurse, Sr Cathy Marsden. This was a Haemophilia Follow-up Clinic, so that this would have been a routine visit. I have no idea who the third person present was or why. It may have been a junior registrar sitting in the clinic to gain experience but I don't know. I note Mr Nevin's comments on the arrangement of the furniture. I have no idea why the furniture was arranged in that way but it was certainly not normally so arranged, and I am unable to attach any special significance to this. Dr McKernan discussed HCV and introduced the subject of Interferon treatment.

5. I reviewed Mr Nevin in the presence of his partner on 10/10/94, when we had a long chat about Hepatitis C (HCV) and discussed the relative merits of Interferon therapy (page 92 of the notes extract provided, WIT3289005). I informed him of the lack of immediate clinical urgency to start treatment, of the 25% response rate to the treatment available at that time, and the treatment side effects. He was not very enthusiastic about this treatment option. The pattern of his blood tests at that time suggested that he had mild liver disease and we discussed liver biopsy. He declined both treatment and liver biopsy at that time, which I think was a reasonable informed decision on his part and one which I would have planned to keep under review (as I said in my letter to the GP). I advised him to moderate his alcohol intake, in line with usual practice. Given that he was accompanied by his partner, although not documented, I would have discussed the low risk of sexual transmission of HCV.

6. I have not seen Mr Nevin since then, since I left to take up a new post six weeks later.

Statement of Truth

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

Signed _____ GRO-C _____

Dated 21st February 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
-	Prof CRM Hay CV	WITN3289002
22.07.94	Serology Report	WITN3289003
07.04.92	Serology Report	WITN3289004
10.10.94	Letter to GP	WITN3289005