Witness Name: Professor Charles Richard Morris Hay
Statement No.: WITN3289178
Exhibits: Nil
Dated: 27 October 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR CHARLES RICHARD MORRIS HAY

I provide this statement in response to a request under Rule 13 of the Inquiry Rules 2006 dated 22 March 2022 in relation to the criticisms by witness W0832 in relation to his late son, BH.

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 W 0832

1. 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.

2. 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.

3. This statement of Witness W0832 was made without the benefit of witness W0832's late son's medical records, since these were destroyed after 8 years by the medical records department, as is their normal practice. Witness W0832 did have a full copy of his notes, but these were destroyed when he moved house – see paragraph 68 of his statement.

4. I also have no access to witness W0832's late son's notes and, since he was only under my care for a short time, 27 years ago, I have no direct recollection of him.

5. Witness W0832's late son was born on GRO-C 1977 and died on 20/3/96. He transferred from the Children's Hospital to Manchester Royal Infirmary at the age of 18, less than a year before he died.

6. At the time of transfer, his HIV care was provided by Dr Mandel at the Infectious Diseases Unit at North Manchester General. I assume that this arrangement continued, given that I had not yet set up a joint HIV clinic with Dr Mandel and subsequently with Dr Ash Sukthanker. North Manchester General did not communicate with us well, and so we usually had little information as to the nature and progress of antiretroviral therapy for out-patients at that hospital, which was very unsatisfactory. This was a very dynamic period for HIV therapy, since triple therapy was introduced in 1995/6 and proved life-saving for a number of our patients who would otherwise have died from AIDS.

7. Clearly, witness W0832's late son already had AIDS or advanced HIV at the time of his transfer, having been infected as a small child. This was a far from ideal time to transfer care, particularly at that time, just as more effective treatment was being introduced, and since we had not yet set up a Joint Paediatric clinic. I can sympathise with many of the comments from BH's father about the "culture shock" of transferring abruptly from a Children's Service to an Adult Service and have long felt that we need an Adolescent Ward for patients in BH's situation.

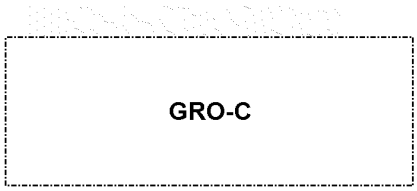
8. Witness 0832 says (para 41) that I "seemed to get angry" with witness W0832's son when discussing his drugs. I have no recollection of this and, since his HIV was being managed by Dr Mandel, I cannot see why I would have been discussing the merits of his HIV therapy, anyway. If I appeared angry then that was certainly never my intention and I am truly sorry if witness W0832's late son formed that view. I may have discussed his Factor VIII treatment since his father describes a severe bleeding phenotype with frequent bleeds. Given that he died less than a year after transfer, I may only have seen him two or three times in outpatients.

Section 3: Other Issues

9. None

Statement of Truth

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

Signed 

Dated 27/10/22