Witness Name: Professor Charles Richard Morris Hay
Statement No.: WITN3289180
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 of Witness W1251, now deceased, in relation to her husband, also deceased.

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 W1251

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 and that of Witness W1251 were made without the benefit of W1251's late husband's medical records, since these were destroyed after 8 years by the medical records department, as is their normal practice. This may account for a number of factual errors in Witness W1251's statement.

4. W1251's late husband had moderate severity Haemophilia A. I was his haematologist from the time I took up post in Manchester (1/12/94) until the time of his death on 5/12/1996, and not from the late 1980s as stated by the witness.

5. Given the severity of W1251's late husband 's Haemophilia, he would not have responded adequately to DDAVP, which was only used from the late 1970's and early 1980's. He would inevitably have required blood product therapy and would have been infected with the, (then-unknown), Hepatitis C virus by some time in the 1970s. To say, as Witness W1251's statement does, that HCV was avoidable had he been given different treatment, is incorrect. There was no alternative treatment to blood product therapy during W1251's late husband 's lifetime.

6. The HCV was first isolated in 1989 and tests became widely available in 1992. Patients were generally tested for this in 1992/3.

7. Patients with Haemophilia at Manchester Royal Infirmary were monitored regularly using liver function tests from about 1980. Witness W1251's statement that Olive Reading told her late husband that he had a "liver virus" in the 1980's is plausible, since he would have been monitored but the virus in question had not been isolated at that time and was known as 'non-A, non-B Hepatitis' (by exclusion of Hepatitis A and Hepatitis B.)

8. From the late 1980's patients with hepatitis were monitored with regular liver function tests once or twice a year, with an alpha fetoprotein [liver cancer marker] test at the same time. Liver ultrasound was generally conducted every couple of years as surveillance.

9. Witness W1251 states that her late husband never had any treatment for his Hepatitis C (HCV). This is correct. At the time of his death, treatment for HCV with Interferon alone, was very much in its infancy and was not very effective, particularly in those Such as W1251's late husband , with cirrhosis.

10. In July 1996, W1251's late husband presented to the Haemophilia Centre with a foot injury requiring treatment. I took the opportunity to check his liver function tests and alpha fetoprotein. We recalled him urgently and referred him urgently to Dr Tom Warnes, Consultant Hepatologist, because his alpha fetoprotein came back very high. This suggested that he may have developed hepatocellular carcinoma (HCC) secondary to Hepatitis C. I also discussed the case with Dr Warnes on the phone. An abdominal ultrasound was arranged urgently and this confirmed our suspicion that he had developed liver cancer. I particularly remember this case because he was the first in our cohort of patients with bleeding disorders to develop this complication.

11. We did offer W1251's late husband consideration for treatment including liver transplantation. He would have required further evaluation by Hepatology to determine the most appropriate course of action. This, and palliative management would have been provided by Hepatology, since the management of liver cancer falls outside the expertise of a haematologist. Palliative care would have been provided by Hepatology and General Practice.

12. He was referred to Hepatology immediately as soon as we became aware of his elevated alpha fetoprotein level. However, as Witness W1251's statement indicates, he rather withdrew from contact with us. We did reach out to him in the community and had some contact through Meg Oppenshaw, our nurse-counsellor towards the end.

13. It is, of course, every patient's right to withdraw and to refuse treatment and medical contact, as described in Witness W1251's statement. It does inevitably mean, however, that the patient may not receive treatment that might otherwise have been helpful and potentially curative and also that they will have less support during their final illness.

Section 3: Other Issues

14. None

Statement of Truth

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

Signed GRO-C

Dated 27.10.22