Witness Name: Professor Charles Richard Morris Hay
Statement No.: WITN3289182
Exhibits: WITN3289183 - WITN3289185
Dated: 6/2/2023

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 W1155.

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: Response to criticism of Witness W1155

2. In May of 1987, I took up post as Senior Lecturer in Haematology and Honorary Consultant Haematologist 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 on the other hand 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 was 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 was 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 the 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 1970s 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. 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.

11. 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.

12. The HCV virus was first isolated in 1989 and tests became widely available in 1992. Patients were generally tested for HCV antibody in 1992/3 and, later, when it became available were tested for HCV antigen. Patients were tested for hepatitis B from the 1970s, that virus having been isolated in 1967.

13. Patients with Haemophilia at Manchester Royal Infirmary were monitored regularly using liver function tests from about 1980.

14. From the late 80s 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.

15. Witness W1155 transferred his care from Manchester Royal Infirmary to the Royal Liverpool Hospital in 1987, because we had developed a joint-Orthopaedic service and were able to replace his knee. He transferred back to Manchester Royal Infirmary (with many other patients) after I left Liverpool, and took up post as the Director of the Haemophilia Centre at Manchester Royal Infirmary in late 1994. Witness W1155 remains under my care. His HIV-care is provided by an HIV clinic local to him.

16. The two criticisms of Witness W1155, which appear to apply wholly or partly to me are as follows: -

    a. That we did not sufficiently investigate whether he had cleared hepatitis C; and

b. That he did not feel I would support an application for special financial support (which he never approached me about) because he had not reported the symptoms that were relevant to that application to me and therefore there was no documentary support for such an application.

17. When addressing these, I had access to Witness W1155's Manchester Royal Infirmary medical records, but not his Royal Liverpool Hospital records.

18. The possibility of non-A non-B hepatitis was discussed with him after he came under my care and not until tests for HCV became available. When the tests became available, in 1991/2, it was apparent that, as one would expect from his treatment history, he had been exposed to HCV but was no longer actively infected. HCV-antigen tests (PCR) were repeatedly negative. It has been explained to him on many occasions that he has spontaneously cleared Hepatitis C and that his tests for active Hepatitis B are also negative (see WITN3289183, WITN3289184, WITN3289185).

19. Neither HCV nor HBV are active issues, nor have they ever been active issues during the more than 30 years I have been looking after Witness W1155.

20. It is correct that Witness W1155 has not been referred to a hepatologist either by me, his GP, or his various HIV physicians. The reason for this is that he does not require a hepatology opinion and does not have a treatable liver condition.

21. I am happy to support any application for additional benefits or other forms of support when I am asked, and so long as the supporting information is correct and can be substantiated. Increasingly, such applications are judged on the basis of statements from the patient, and a statement from a doctor supported by documentary evidence that the patient's clinical complaints have been documented in the past. For that reason, it can be difficult to support some

applications based on complaints never previously mentioned, until they become relevant to a current application.

Section 3: Other Issues

22. None

Statement of Truth

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

Signed _____ GRO-C: Professor Charles Hay _____

Dated _____6/3/23___

Table of exhibits:

Date	Notes/ Description	Exhibit number
3.06.04	Letter Professor Hay to Dr GRO-B	WITN3289183
26.08.04	Letter Dr Ruell to Dr GRO-B	WITN3289184
23.02.05	Letter Professor Hay to Dr GRO-B	WITN3289185