Witness Name: Professor Charles Richard Morris Hay
Statement No.: WITN3289186
Exhibits: None
Dated: 6/3/2023

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 W3019 in relation to her late brother.

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 W3019

2. 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.

3. 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.

4. I do not have access to the medical records of Witness W3019's late brother because they have been destroyed after 8 years by the medical records department, as is normal practice.

5. Witness W3019 has two criticisms that appear to be directed towards me in relation to the care of her late brother, who died from AIDS on 18/3/1994. These are as follows:
    a. That we retained DNA, which I informed her of during genetic counselling in 1997, may be useful for carrier testing to assist her in planning her family. In her statement she says she is shocked that we retained such samples after

death and suggests that these were obtained without consent, and for research.

b. That neither I nor my team visited Witness W3019's late brother in the three weeks before he died.

6. I am unable to comment on the substance of the second complaint since I did not take up post at Manchester Royal Infirmary until 8 months after Witness W3019's late brother sadly died. I never managed him or even met him.

7. In relation to her reaction on learning that we might have stored DNA for genetic analysis, I have no direct knowledge of the consent process that W3019's late brother went through, because it obviously predates my taking up post in Manchester. However, consent was taken routinely for genetic testing in the 1980s and 1990s. At that time this would probably have been verbal consent and was followed by written informed consent in the early 1990's. This included informing the patient and consenting to retaining the DNA sample *indefinitely.* The purpose was to enable us to retest the sample along with samples from other family members, obtained for the purpose of carrier testing. In that circumstance, the sample from the index case (in this case Witness W3019's late brother) would be used as a control sample. In the absence of a sample from the index case, it may not be possible to establish whether a female relative is a carrier of Haemophilia.

8. The sample is retained for clinical purposes to help relatives and offspring to establish if they carry the Haemophilia gene and is *not* retained for research purposes. It is clear from Witness W3019's statement that I explained this to her when I saw her for genetic counselling in 1997.

9. It is not surprising that Witness W3019 was unaware of the retention of a sample since consent would have been taken from Witness W3019's late brother and not his relatives.

Section 3: Other Issues

10. None.

Statement of Truth

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

Signed _____ GRO-C _____

Dated _____6/3/23_____