Witness Name: Professor Charles Richard Morris Hay

Statement No.: WITN3289191

Exhibits: Nil

Dated: 14/6/2023

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF PROFESSOR CHARLES RICHARD MORRIS HAY**

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I provide this statement in response to a notice under Rule 13 of the Inquiry Rules 2006 dated 22 August 2022 in relation to the criticisms of Witness W1189, dated February 2019. This statement was submitted to my legal representatives in late August 2022.

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 W1189**

**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. When I took up post in Manchester in December 1994 I found that patients with mild bleeding disorders had not been followed systematically and many (hundreds) were consequently lost to follow-up. I audited these and sent them appointments. Witness W1189 was one of these, who I remember specifically because of the very unusual circumstances following his consultation. We had very few patients with HCV who

were picked up late because they had been lost to follow-up.

5. I sent Witness W1189 an appointment for review, some time in 1995, which he did not keep. He was an HGV driver. HGV drivers are often difficult to follow up because of their very variable and unpredictable work pattern. He had moderate severity von Willebrand's disease, a relatively mild bleeding disorder.

6. We invited him for an appointment again in 2000 and he attended with his wife. I remember making what was intended as a lighthearted remark that he was five years late for his appointment. He was quite anxious, and I don't think appreciated the comment. When I went through his medical records it was clear that he had been treated with concentrate 20 years before, during the period of risk for HCV but not I think, during the period of risk for HIV. I therefore told him that it was likely that he had been exposed to HCV, that he may or may not have cleared it, and that if he did have it there was treatment that we could use to eradicate it. I would have outlined the generally good but variable outlook of HCV and would have discussed further investigations. I would have questioned him about his alcohol intake. This frequently causes offense, but is a routine, since there is an interaction between alcohol and HCV and all patients with HCV are asked to moderate their alcohol intake.

7. Witness W1189 complains that I only outlined the situation at that time. He was obviously and understandably quite shocked by this news. Giving him only an outline at that stage is a strategy used to avoid 'information overload'. Informing a patient fully is a multistage process. I will often actually say to the patient that there are a lot more details that I will share with them at a later stage and that we should just start just with the basics. I would always offer the patient the opportunity to ask questions at the end of any consultation. Those questions often only occur to the patient after they have left the room.

8. As Witness W1189 recounts, this consultation was followed by meetings with our nurse counsellor Meg Openshaw, and further consultations with me to discuss the outlook, the results of his tests, treatment to eradicate the virus, and potential side-effects of treatment. Meg would also offer pastoral support during treatment for HCV because patients often struggle with the side-effects and need a lot of support.

9. Witness W1189 was very keen to try eradication treatment. I was a little anxious about this because he admitted to depression. Patients with a history of depression are

particularly susceptible to severe depression whilst undergoing treatment with interferon-based regimens. This is a very common treatment-related side-effect affecting 40% of patients in clinical trials. This depression can be very severe, continue
after treatment finishes, and has sometimes caused suicide. He and his wife would have been well prepared following the consultation prior to starting. It was my practice to request the patient to bring their wife with them for pre-treatment counselling about side effects because often the whole family struggles and I can think of at least one marriage that foundered because of the treatment-induced personality change during treatment to eradicate HCV.

10. Witness W1189 had a pretty awful time on treatment, which lasted for 12 months. He was compliant and stuck with it, however, and his HCV was successfully eradicated.

11. In about 2004 we were joined by a further consultant and his care passed to Dr P Bolton-Maggs.

**Section 3: Other Issues**

12. None

**Statement of Truth**

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

Signed GRO-C

Dated 14/6/23