Witness Name: Professor Charles Richard Morris Hay
Statement No.: WITN3289196
Exhibits: Nil
Dated: 14/6/2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR CHARLES RICHARD MORRIS HAY

I provide this statement in response to a notice under Rule 13 of the Inquiry Rules 2006 dated 20 October 2022 in relation to the criticisms of Witness W1326 dated 30 January 2019.

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 W1326

2. This response has been prepared without access to the patient's MRI Medical records because W1326 has withheld consent. 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. Witness W1326 has severe haemophilia A and was infected with Hepatitis C from his treatment but fortunately cleared this spontaneously many years before he first came under my care in 1994. His HCV PPCR test was consistently negative and his LFTs
normal. He remained under my care until I arranged to transfer his care to the Liverpool Centre in 2003.

5. In paragraph 18 Witness W1326 alleges a delay in me informing Liverpool Royal Hospital of his exposure to batches of concentrate implicated in a donor who developed vCJD. Since I do not remember this and the witness has not consented to me accessing his medical records, I am unable to check the details or respond to this allegation. I would say that paragraph 19, in which Witness W1326 states that the government advised that patients should not be told about vCJD is incorrect. Since there was no test for vCJD, or treatment, patients were to be given a choice about whether they would be informed whether they had received an implicated batch. Their choice in this matter was recorded.

6. In paragraphs 55-57 of his statement, Witness W1326 gives his incorrect account of previous complaints, which he appears to have conflated, and which he incorrectly states were not taken seriously by the Manchester Royal Infirmary. These ultimately formed a part of a complaint he made to the General Medical Counsel, which the GMC concluded was without foundation, and closed. I am therefore able to respond to the criticisms concerning access to his medical records in paragraphs 56 and 57 of his statement in detail, and without recourse to those medical records.

7. In May 2002, Witness W1326 requested to see his notes. I signed the form on 31 May 2002, giving him permission to view all his medical records. I have never withheld consent for patients to see their notes, and the grounds for

withholding consent are extremely restricted. I did not go through his records before he saw them, having no reason to do so.

8. I subsequently reviewed him in clinic in June 2002. The main thing he wished to discuss was his treatment record, which he had reviewed a few days earlier. He told me that he was viewing his records to see if he had been treated with Koate (a brand of Factor 8 used in the 1970s and early 1980s), in the early 1980's. He wanted this information to see if he could participate in a class action mounted on a contingency basis by a firm of American lawyers. He said that he had been unable to find what he wanted.
9. Although this was a poor use of clinic time, I spent the better part of 45 minutes going through his notes, and pointed out the annual treatment summaries, which are filed at the back of the notes. These are filed in a sheaf close together. I can only assume that he didn't know what he was looking for because they are easy to find and have been filed in that position in his case-record for the last 20 years. These confirmed his expectation that he had been treated with Koate. During this consultation, I explained to him that he had earlier been treated with a BPL product and had therefore probably contracted Hepatitis C from UK domestic Factor 8 concentrate. It may be that he did not understand this. He asked if he could photocopy the relevant records. I said that would be fine, but he would have to follow the formal policy through the medical records department. No further permission is required, and patients can view records repeatedly, at no extra charge.

10. The patient was subsequently unable to find these printouts when he looked through the notes on his own, and re-presented to the department, when he was assisted by the nursing staff, and they were pointed out to him again. He claimed that they had not been there previously when he looked through the records with me. They were filed and have remained in his records since the mid-eighties. His notes have not been re-bound during that time and we have no reason to remove these records, far less take them out and put them back in, as he appears to be suggesting.

11. These printouts are not detailed. They do not list batch numbers but do list how much of which products were used in a given year. I do not believe that the centre kept detailed records with batch numbers 30 years ago. Since taking over the centre in 1994, we have developed a comprehensive centre database and now keep such detailed records. All the records that we possess have been made available to Witness W1326 on each occasion that he has requested them. Paragraph 56 of his statement is incorrect. There are no "green folders", and what he was looking for is and was filed in the main body of the notes.

12. In autumn of 2002, Witness W1326 made a complaint against me and the Haematology social worker, through the Trust complaints procedure. Contrary to paragraph 57 of his statement, this complaint was taken seriously and went through the hospital formal complaints procedure. We followed the hospital complaints policy and arranged a meeting for early January 2003 between Witness W1326, me, Sir Michael Deegan, the Chief Executive, and Mrs Gillian Heaton, the Head Nurse.

13. The substance of the complaint was that he alleged that discussion between me and the social worker (a member of our multidisciplinary team) in relation to an application for the higher rate living allowance, constituted a breach of confidentiality. We had concluded that this application was inappropriate, with reference to the eligibility criteria. During this meeting he was personally abusive. His complaint was not upheld.

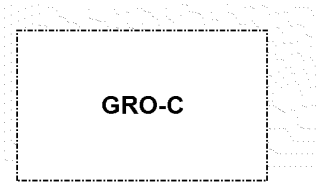
14. He was also advised that we felt that it was appropriate to transfer his care to the Liverpool Centre. I referred him on 8 January 2003, but in early February 2003 he requested, through Mr Deegan's office, to return to my care. This request was declined.

Section 3: Other Issues

15. None.

Statement of Truth

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



Signed

Dated 14/6/2023