Witness Name: Dr Roger McCorry
Statement No.: WITN3320001
Exhibits: WITN3320002 – WITN3320012
Dated: 16 October 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ROGER MCCORRY

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 May 2019.

I, Dr Roger McCorry, will say as follows: -

Section 1: Introduction

1. My name is Dr Roger Boyd McCorry. My date of birth is GRO-C 1978 and my professional address is the Liver Unit, 1st Floor East Wing, Royal Victoria Hospital (RVH), Grosvenor Road, Belfast. My qualifications include a bachelor of medicine and surgery degree (MB BCh BAO) awarded by Queen's University Belfast in 2001, membership of the Royal College of Physicians (MRCP) granted in 2004, MRCP Gastroenterology awarded in 2010 and a Post-Graduate Diploma in Gastroenterology awarded by the University of Salford in 2012. I was elected to Fellowship of the Royal College of Physicians (FRCP) in 2017.

2. I was appointed to my current post as a Consultant Hepatologist in the RVH Liver Unit in January 2014. I was awarded a certificate of completion of specialty training in gastroenterology and general (internal) medicine with sub-specialty accreditation in hepatology in 2012 and subsequently occupied the posts of Locum Consultant Gastroenterologist in Royal Preston Hospital from October 2012 until August 2013 and Consultant Gastroenterologist and Hepatologist (substantive appointment) in the University Hospital of South Manchester between August 2013 and January 2014. Prior to this, I was a specialty trainee in gastroenterology in the North Western Deanery (England) and completed a 1 year hepatology training post in Addenbrooke's Hospital (Cambridge) Liver Transplant Unit and Queen's Medical Centre (Nottingham) Liver Unit.

3. I am a member of the British Association for the Study of the Liver (BASL) and the British Society of Gastroenterology (BSG).

4. I am an active advocate for patients with alcohol use disorders. I have occupied the role of alcohol lead for the Belfast Health and Social Care Trust since 2014, chairing the Alcohol Care Team. I was co-author of the Northern Ireland Alcohol Use Disorder Care Pathway (2017) which sought to improve and standardise the care of patients with alcohol use disorder across Northern Ireland. I was heavily involved in the development of the Belfast Trust's Alcohol Recovery Centre (ARC), which is a multi-agency partnership providing support and care to acutely intoxicated patients on a Friday and Saturday night. I am currently a member of the steering group overseeing the launch of a Leonard Cheshire residential facility to provide rehabilitation to patients with alcohol related brain injury. I chair the Department of Health's Treatment Support and Advisory Committee. This is a regional body that

reviews developments in services supporting patients with alcohol and substance misuse issues and advises on policy. In 2017, I was the Northern Ireland representative on a committee convened by Public Health England to review higher risk drinking advice.

5. I often work with patient groups and charities on a voluntary basis to raise awareness of liver disease, both as part of my job and in my personal time, to promote population liver health. This includes participation in the British Liver Trust's 'Love Your Liver' campaign and regular attendance to support the Royal Victoria Hospital Liver Support Group (a Northern Ireland - wide charity).

6. As a liver specialist I work with patients from a diverse range of socio-economic backgrounds and ethnic groups. Many of these patients have rare conditions and unfortunate circumstances not of their own making.

7. In 2014 I undertook a course on Advanced Communication Skills Training for Healthcare Professionals working in Cancer and Palliative Care with the aim of both improving my communication skills and aiding my management of challenging situations.

8. I have not been a member, past or present, of any committees or groups relevant to the Inquiry's terms of reference.

Section 2: Response to criticism of Christina McLaughlin

9. I received an email on 20th May 2019 at 10.56am to my personal email account from Jessica Whitehead, acting on behalf of the Infected Blood Inquiry, to notify me I was being issued with a rule 9 request to provide a written statement. This resulted from professional criticism by a witness providing oral evidence to the inquiry on 23rd May 2019. The witness's written statement was signed and dated 22nd April 2019.

10. I was informed that I would usually be given 21 days in which to provide my statement. However, given the oral evidence was being heard on 23rd May 2019 this gave me three days in which to submit evidence if I wanted my statement to be available at the time of the witness's evidence being heard at the inquiry. It was made clear I could still choose to take 21 days and if I did my statement would still be considered by the inquiry.

11. The professional criticism from the witness (Christina McLaughlin) alleges that I told her brother Seamus Conway that his liver cancer was as a result of alcohol consumption rather than hepatitis C infection. Ms McLaughlin refutes that Mr Conway was an alcoholic, stating that he only drank "socially".

12. I personally recall my two consultations with Mr Conway very clearly. I did not have any interaction with Mrs McLaughlin. I have referred to Mr Conway's medical records and contemporaneously dictated letters along with my recollection of my consultations with him in compiling this statement.

13. Mr Conway was referred to the regional liver service by Dr Gary Benson, Consultant Haematologist, and was initially reviewed by my consultant hepatology colleague, Dr Neil McDougall, at the RVH liver clinic on 6th October 2017.

14. This consultation was arranged to assess suitability for treatment of hepatitis C (genotype 3). Mr Conway had previously had a failed attempt at treatment with

Interferon with the haematology team, providing follow-up of his haemophilia, in 1995. He was not previously known to our service.

15. Documented in the consultation letter Mr Conway reported an alcohol intake of 'approximately 6 to 8 beers on two separate nights per week' to Dr McDougall. I would refer to exhibit number WITN3320002 which is correspondence from Dr. McDougall to Dr. Gary Benson following a clinic on 6 October 2017 attached hereto. This would equate to around 30 units of alcohol on a weekly basis. The Chief Medical Officers' guidelines (2016) recommend drinking no more than 14 units a week to keep health risks from alcohol at a low level. The AUDIT-C is a widely validated alcohol screening tool created by the World Health Organisation and endorsed by the Northern Ireland Alcohol Use Disorder Care Pathway as the screening tool of choice in all Healthcare Trusts in Northern Ireland. I have attached a copy of AUDIT-C hereto at exhibit WITN3320003. Applying the three questions of the AUDIT-C to Mr Conway's documented alcohol history would equate to a score of 10 out of a total of 12. An AUDIT-C score of greater than or equal to 8 indicates higher risk drinking.

16. Mr Conway acknowledged to Dr McDougall that his alcohol intake had previously been heavier than this over a three or four year period.

17. Dr McDougall discussed the potential for treatment of hepatitis C, with Mr Conway, using directly acting anti-virals without the requirement for Interferon. Given Mr Conway was deemed to be an appropriate candidate and expressed a keenness to pursue treatment he was added to the waiting list.

18. Dr McDougall arranged for Mr Conway to receive appointments to undergo an ultrasound scan of liver (to exclude liver cancer) and Fibroscan (to assess if there was underlying damage to his liver).

19. A Fibroscan, performed on 15th November 2017, confirmed definite liver cirrhosis (liver stiffness measurement 75 kPa (IQR 0.7)). Liver cirrhosis represents advanced damage within the liver. The blood markers of synthetic liver function (bilirubin, albumin, INR) were normal and he had no features of decompensation (liver failure). Using the Child Pugh score to assess liver cirrhosis he would have been considered Child Pugh class A5. Based on this result Dr McDougall arranged for him to be prioritised on the waiting list for treatment of hepatitis C.

20. Mr Conway attended for a pre-treatment visit with our viral hepatitis nurse on 5th January 2018 and he was also reviewed at my clinic by a senior house officer (SHO) but was not seen by me. Blood tests including alpha-fetoprotein (AFP – a tumour marker for hepatoma) were performed and an ultrasound scan arranged. This was to be performed prior to initiating hepatitis C treatment.

21. The AFP was markedly elevated at 2156 (normal range 0 – 10) and indicated a high probability of hepatoma.

22. Ultrasound scan on 10th January 2018 led to a CT scan of chest abdomen and pelvis on 20th January 2018. This confirmed multi-focal hepatoma with evidence of portal vein thrombosis (clot in the main vein supplying blood to the liver).

23. Hepatoma is a form of primary liver cancer associated with liver cirrhosis. It is well established in the medical literature that there is a synergistic relationship between hepatitis C and alcohol consumption in terms of accelerating hepatic fibrosis (scarring) and the development of hepatoma. A recent study by Vandenbulcke et al

has demonstrated that even with light to moderate alcohol intake there is three-fold (hazard ratio 3.43) increased risk of hepatoma in patients with hepatitis C related liver cirrhosis. I attach a copy of the study hereto at exhibit WITN3320004.

24. I arranged to review Mr Conway personally, for the first time, in the presence of one of our viral hepatitis nurse specialists on 23rd January 2018. Mr Conway was unaccompanied.

25. I explained to him that the CT scan complemented by the AFP had confirmed the diagnosis of hepatoma. I also discussed potential options for treatment. Given the severity of his liver disease and extent of the hepatoma a surgical resection would not have been an option. The AFP of greater than 1,000 meant that liver transplant was immediately excluded. I also provided him with a brief overview of palliative treatment options such as transarterial chemoembolization (TACE) and radiofrequency ablation (RFA).

26. I explained that his case would be discussed in our specialist cancer meeting (Hepatopancreatobiliary Multi-disciplinary team Meeting (HPB MDM)) on 26th January 2018 and an MRI scan of liver was also planned. The HPB MDM comprises surgeons, radiologists, oncologists (cancer specialists), physicians and clinical nurse specialists. He was advised that we would stall on treatment of hepatitis C until a clear plan was in place for management of the hepatoma.

27. Following discussion in the HPB MDM on 26th January 2018 it was agreed to defer a decision on treatment until following the MRI scan of liver.

28. The MRI scan was performed on 1st February 2018 and was followed by further HPB MDM discussion on 9th February 2018. This established that the extensive hepatoma with tumour thrombus in the portal vein would preclude loco-regional therapies (TACE, RFA, selective internal radiation therapy (SIRT)) and his only treatment options would be systemic chemotherapy with Sorafenib or palliative care.

29. I reviewed Mr Conway in the liver clinic on 16th February 2018 in the presence of our HPB clinical nurse specialist (HPB CNS). He was initially unaccompanied.

30. At length I explained the outcome of the MDM to Mr Conway and reasons why liver transplant, surgical resection, TACE and SIRT were not options in his case. I discussed the option of treatment with Sorafenib through our oncology service in the Belfast City Hospital Cancer Centre. Based on the side effect profile and uncertainty as regards whether it would prolong survival in his case Mr Conway was very clear that he did not wish to pursue the option of Sorafenib.

31. He was keen I be explicit regarding prognosis and I advised him it was poor and was likely to be less than 6 months. The recommendation is that hepatitis C treatment is not offered unless prognosis is greater than 12 months on grounds of futility and therefore this was no longer an option for him.

32. Mr Conway asked that I break the news to his teenage daughter Jennifer, who was at that point in the waiting area. The HPB CNS and I met with Jennifer in the consultation room whilst Mr Conway returned to the waiting area. We did our best to offer the news to Jennifer in a form she could understand.

33. Mr Conway declined an onward referral to the palliative care team at that time but agreed to have ongoing discussions with our HPB CNS regarding this. Our HPB CNS spent some time with him and Jennifer following my consultation, in a private

room, to offer emotional support. She offered them a card with the HPB CNS contact details and I arranged a further review in 4weeks. I do not recall and did not document if I also provided Mr Conway with my business card (this would have listed the telephone numbers of the Liver Unit secretaries).

34. Mr Conway failed to attend for a scheduled review at my clinic on 21 March 2018. I wrote to him explaining I would be happy to arrange a further review on request.

35. Having consulted her electronic records the HPB CNS has advised she made phone contact with Mr Conway on 21st February 2018 and again offered emotional support. He was agreeable to onward referral to district nurses and a DS1500 form (for claiming attendance allowance in the event of a terminal illness) was discussed. He was also offered the contact details of Action Cancer to arrange counselling for Jennifer.

36. Further phone contact with the HPB CNS occurred on 6th March 2018 at which point Mr Conway reported feeling very well without any issues. The nurse explained that she would not plan on ringing him again and made him aware he should get in contact if he had any questions or queries.

37. As a healthcare professional it is always extremely challenging to break bad news, particularly in circumstances where the patient is unsuspecting, and the prognosis is poor. I recall and have documented in my first clinic letter that Mr Conway was very upset by the hepatoma diagnosis. Both I and my nurse colleagues did our best to conduct the consultation in a compassionate way and offered him emotional support in the context of the very tragic circumstances that had befallen him.

38. In response to Mrs McLaughlin's criticism of me in point 22 of her witness statement I have no evidence that I took an alcohol history from Mr Conway. I would, however, have referenced Dr McDougall's alcohol history documented in point 15 above.

39. I did not document my discussion with Mr Conway regarding the aetiology (cause) of his liver cirrhosis. My firmly held expert opinion is that the hepatitis C led to liver cirrhosis and ultimately hepatoma in his case but, almost certainly, his alcohol consumption was likely to have been a significant co-factor in this as I have alluded to in point 23 above. This may have led to me suggesting, to Mr Conway, that his lifestyle may have had a role to play in his final illness.

40. Both my consultations with Mr Conway were highly emotional for him given the gravity of the information I had to impart. In addition, there was a large volume of medical information for him to take on board and digest. We appreciate, as healthcare professionals that often it can be challenging for patients to accurately recall specific details following these challenging consultations.

41. I never use the term 'alcoholic' either with my colleagues or patients as I believe it creates a stigma we, as a society, need to move away from. I have no evidence that Mr Conway was dependent on alcohol but I do believe there is clear evidence from the medical records that he had potentially drank at a level harmful to his health. I would refer to exhibits WITN3320005 – WITN3320012 which are relevant extracts from Mr. Conway's notes and records.

42. In point 30 Mrs McLaughlin states that she rang the RVH Liver Unit office on seven occasions seeking to speak to me during Mr Conway's final illness. The Liver Unit secretaries have reviewed their log book of answer phone messages received

between February and May 2018 and have not found any evidence that she left an answer phone message requesting a call back.

43. Clearly Mr Conway's untimely death must have been absolutely devastating for his family and I would like to pass on my sincere condolences to them. This is particularly so given the manner in which he acquired hepatitis C. It is of course deeply regrettable that the RVH Liver Unit were not in a position to offer him modern, effective hepatitis C therapy at a time point before he developed liver cirrhosis and hepatoma.

Section 3: Other Issues

44. I have no other relevant evidence to submit.

Statement of Truth

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

GRO-C

Signed

16th October 2019

Dated

Table of exhibits:

Date	Notes/ Description	Exhibit number
6 October 2017	Dr McDougall, outpatient clinic letter	WITN3320002
undated	AUDIT-C Questionnaire	WITN3320003
13 May 2016	Vandenbulcke et al. Journal of Hepatology 2016, vol. 65, 543–551	WITN3320004
16 March 2011 and 28 August 2013	Blood Alcohol Level Results	WITN3320005
17 January 2014	Dr. Benson, outpatient clinic letter	WITN3320006
10 March 2014	Altnagelvin Hospital discharge summary	WITN3320007
19 September 2014	Altnagelvin Hospital discharge summary	WITN3320008
14 October 2014	Altnagelvin Hospital discharge summary	WITN3320009

22 September 2014	Mr Swain, Fractures Ward Round letter, Royal Victoria Hospita	WITN3320010
21 November 2014	Dr Benson, outpatient clinic letter	WITN3320011
17 October 2016	Altnagelvin Hospital discharge summary	WITN3320012