Witness Name: Dr Eleanor Goldman
Statement No.: WITN3067001
Exhibits: None
Dated: 2 May 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ELEANOR GOLDMAN

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 15 March 2019.

I, Dr Eleanor Goldman, will say as follows: -

Section 1: Introduction

1. I am Dr Eleanor Goldman, of GRO-C My date of birth is GRO-C GRO-C 1930. I qualified from the University of Witwatersrand in South Africa, obtaining the Degree MB BCh in 1952. I became fully registered with the GMC in September 1953. Between 1970 and 1974 I worked as a Medical Officer at the Far East Rand branch of the South African Institute for Medical Research in the general pathology laboratory. Between 1976 and 1984, I was Clinical Assistant to Dr Katherine Dormandy at the Haemostasis and Thrombosis Centre at the Royal Free Hospital in London. Between 1984 and 1995 I was an Associate Specialist in Haematology, again at the Royal Free Hospital. I retired fully from medical practice in 1995, and relinquished my registration with the General Medical Council on 1 January 2009. I am now 88.

Section 2: Responses to criticism

2. Before responding to the criticisms set out in the Rule 9 request letter dated 15 March 2019, I would like to provide some background information.

3. The Haemostasis and Thrombosis Centre at the Royal Free Hospital was established by the late Dr Katherine Dormandy to provide comprehensive care for patients with bleeding and clotting disorders. This was to include medical treatment and social and psychological support, enabling patients to lead as normal a life as possible. With the development of replacement concentrates, patients were put on home treatment which was administered by parents, and as soon as possible by the patients themselves, with parental supervision as necessary. Patients would be seen on request at any time of day or night. There was also regular general reviews arranged annually or six monthly.

4. Patients were referred to specialist departments as and when necessary – including orthopaedics, gynaecology, hepatology and paediatrics. A special orthopaedic clinic was held monthly with Mr J C Madgwick (orthopaedic consultant), and subsequently Mr N Goddard, to see selected patients with orthopaedic complications of haemophilia, which were not uncommon. Later I arranged for similar clinics with the Head of Paediatrics.

5. My role was to treat patients with acute bleeds as well as seeing them for annual review. At these reviews they were also seen by a full time social worker, Mrs Riva Miller. Mrs Miller was trained as a family therapist at the Institute for Family Therapy. Realising that haemophilia was a family issue, I attended an introductory family therapy course at the Institute for Family Therapy, and a course in systemic family therapy at the Tavistock Clinic.

6. With the agreement of Dr Peter Kernoff, then the Director of the Centre, Mrs Miller and I arranged to see patients together, at the beginning of a review, to explore social or psychological needs. I provided genetic counselling when requested, and later HIV counselling. I was the co-author of a book on Counselling in HIV, with R Miller and R Bor.

7. Counselling sessions were videotaped with the patients' consent, so that we could review the sessions afterwards and plan any future interventions in line with usual practice. The purpose of the tapes was explained to the patients and they signed consent forms which were filed in their clinical records. In the case of children, parents signed the consent form on their behalf.

8. During the 1970s, it became apparent that there was a form of Hepatitis which was neither positive for Hepatitis A nor Hepatitis B antibody tests. This new strain of Hepatitis was initially referred to as "non A non B Hepatitis". Patients being treated

with blood products were noticed to have minor abnormal liver function tests whilst remaining negative for Hepatitis A and/or Hepatitis B. With the advent of recombinant gene technology, it became possible to identify the virus responsible, which was named Hepatitis C. As soon as a test for Hepatitis C became available in 1990, all patients being treated with blood products at the Centre were tested. Many were found to be anti-Hepatitis C virus positive. Dr Christine Lee, Consultant Haematologist and Director of the Centre wrote to all patients affected, to inform them of their results.

9. I was involved with Patient NH's care between 10 July 1985, and my retirement in 1995. Although I remember NH and his family, I now have no direct recollection of the individual consultations, given that they occurred between 24 and 34 years ago. I am therefore entirely dependent upon my standard practice, the medical records and correspondence that have been disclosed to me with the Rule 9 request. I have not requested or had access to any other documentation for the purposes of producing this statement. The records and correspondence that have been disclosed are clearly incomplete, and I would have had further documented contacts with NH and his family during the period in which I was involved in his care. There were also video recordings as described below.

10. I note the very limited criticisms set out in the Rule 9 request. I have also carefully read the entirety of Mrs DH's statement dated 8 February 2019, and I have responded in particular to paragraphs 39 and 46 - 52 of that statement. I am grateful for Mrs NH's comments in paragraphs 38 and 91 of the statement.

"At paragraph 48 of her statement Mrs NH exhibits a letter sent by you to Nick's General Practitioner Dr R, advising that Nick had returned a positive result for Hepatitis C (HCV). The letter also advised that Nick's parents were aware that HCV testing was being undertaken, but had not been informed of the test result. Mrs H disputes that she was told about the HCV testing, and also claims that she was only informed of Nick's positive test result 3 weeks later."

11. My records for the relevant consultation read as follows:

"5/6/90 Review (videoed) seen with RM (Riva Miller) Mr + Mrs H, GRO-C Nicholas
2-3 bleeds per month miscellaneous sites
Usually treats himself
Keeps treatments at school – parents bought fridge and supply sharps box
General health good

Eczema on scalp. Seen at GOS by dermatologist – Dr Atherton
Cortisone cream
Complains of being tired
Infected verruca drained spontaneously
Eats "junk food"
Teeth good no fillings
Writing exams at school
Discussed family rows – see video
O/E wt 43.3kgs Ht 164cms
B.P. 110/70. No lymphadenopathy *Eczema in both elbow flexures*
Chest clear *and over occipital region Liver*
and spleen not palpable no masses
Routine blood samples
Samples taken for gene
probes
Discussed anti HCV with Mrs H and Nicholas
(our emphasis)
Review 6/12
Appt arranged with Robert Milnes for
21/6/90 (at parents request)"

12. To the best of my knowledge, no HIV or Hepatitis C testing had occurred for NH at Great Ormond Street. HIV testing was available from 1984/85 onwards and Hepatitis C testing was introduced in 1990. As soon as the tests were available, all patients in receipt of blood products were routinely tested.

13. The blood samples taken from NH on 5 June 1990 *subsequently* tested negative for HIV, but positive for Hepatitis C. My note suggests that anti Hepatitis C virus testing had been discussed with NH at the appointment on 5 June 1990. The note also confirms that the consultation was videoed. As discussed below, I believe the video tapes have been retained, and therefore should confirm definitively what was discussed.

14. There is also a relevant entry for a consultation that occurred a year later, on 24 July 1991, which reads:

> *"Reference to `Hepatitis` was clearly not wanted by the parents, and this was not pressed. NH said he vaguely remembered discussing it last year"*

15. By 22 June 1990, we had clearly received the blood test results, and notification that NH had tested positive for anti HCV. My letter to the General Practitioner Dr R, dated 22 June 1990, confirms the position and clearly states that although NH and his parents were aware that the anti HCV test had been performed, they had yet to be informed of the result.

16. There is an administrative entry dated 26 June 1990 which reads:

"Noted to have protein in urine. Request repeat sample. Repeat urine sample – no white cells, occasional red cells, no growth."

17. My practice at that stage would have been to have broken bad news of this type to the patient and his parents in person, during a face to face consultation. However as the records confirm, I did not see NH or his parents again until 14 August 1990. In the meantime Dr L had written to Mr and Mrs H on 9 July 1990 confirming the positive test result.

18. I next saw NH and his family in consultation on 14 August 1990. This was again a joint consultation with Riva Miller, who on this occasion has compiled the medical record, which reads as follows:

"14.8.90 Follow up counselling session with family EG/RM

Videoed

1. *Want to discuss EG's intervention that baffled them all. Want an explanation.*
2. *Related the huge changes since they were last here."*

19. I am not sure whether this note is complete, given that it appears at the foot of a page numbered 127, and page 128 then starts with an earlier appointment dated 25 October 1989. I do not know to what the reference to "EG's intervention" relates, although I note Mrs H's comments in paragraph 49 of her statement. It may have related to counselling in relation to GRO-C rather than the recent positive test result for HCV. I see that the consultation is noted as having been videoed, and therefore the recording should confirm what was discussed. Given the limited written note, and given that I have not viewed any recording of the consultation, I cannot comment further.

"At paragraph 49 of her statement, Mrs H claims that meetings she had with you were regularly videotaped, despite Mrs H not providing her consent.

20. As I have indicated in my introductory comments, all consultations, involving a counselling aspect were videoed, subject to the consent of the patient or, where appropriate, the patient's parents. Prior to the first consultation being recorded, the patient and his, or her parents, would be provided with a full page consent form, together with a verbal explanation. They would be informed that Mrs Miller and I would like to interview them together and to record the consultation on film. We would secure fully informed consent before the recording was commenced. We would explain that the purpose of the recording was to enable us to review the video after the consultation, in order to assist with the management plan with particular reference to further counselling. We would make clear that the recording would not be shown to anyone else without their consent, save for other healthcare professionals directly involved in their treatment, and/or used for training purposes.

21. I cannot recall any refusals in response to requests to video record the consultation. The consent form, once signed, was filed with the patient's records. Although I cannot be certain, I would have thought that for obvious reasons, the consent process was dealt with before the video recording equipment was switched on. The video recordings were stored in a locked filing cabinet.

22. Written consent would only be obtained prior to the first consultation to be recorded. Thereafter, consent would be assumed. The patient and his parents would see us switching on the recording equipment, and announcing that we were doing so. Any objection (and I can recall none), would result in the consultation not being recorded. At the start of the tape recorded consultations, the patient and his parents would be able to see themselves on the television monitor within the consulting room, although this would then be switched off, to avoid distraction. Patients were always aware that the consultations were videoed – indeed some specifically asked to review their own recordings.

23. Because the notes are incomplete, I have been unable to identify the first consultation that was video recorded. I note that there is a specific entry confirming that the consultation of 19 February 1990 (in which we were joined by Riva Miller) was recorded. Similar entries appear for the consultations on 5 June 1990 (see above), 14 August 1990, 24 January 1991, 17 April 1991, 15 May 1991, and 24 July 1991 as Mrs H identifies in her statement.

"At paragraph 50 of her statement Mrs H refers to a meeting she had with you on 14 November 1990 to discuss her son's constant tiredness. Mrs H exhibits a letter from you to Nick's GP, Dr R, in which you suggest that some of his tiredness could be attributed to depression. You do not mention HCV in this letter at all, despite the fact that Nick had been diagnosed with HCV in 1990."

24. The letter to Dr R dated 27 November 1990 followed a telephone conversation with Mrs H on 14 November and a consultation with NH on 15 November 1990, which are entered in the records as follows:

"Telephone call from Mrs H

"14/11/90 *Off colour for several weeks. Always tired. Doesn't look well. GP suggested he might have glandular fever. Now has discharging ear suggested he come to the Centre for examination and blood tests."*

"15/11/90 *Feels tired*
Has missed 2 days school in the past 2/52 and 6/days in the previous
1/2 term
Eats reasonable diet
(noted to have low Mean Corpuscular Volume in June – 78)
Diarrhoea for 1 day last week otherwise no gastro-intestinal, genito-urinary or respiratory
symptoms
O/E wt 44.1kg Ht 168cms B.P. 90/60
acne
throat clear
no lymphadenopathy
RS)
CVS) N A D
Abdomen)
Full blood count + erythrocyte sedimentation rate + monospot + iron + total iron binding capacity
Liver function tests
Urine for microscopy, culture and sensitivity"

25. Consequently, after a telephone discussion with Mrs H on 14 November 1990, I saw NH in consultation the following day. In particular his General Practitioner had suggested that he might have glandular fever. The GP's provisional diagnosis of glandular fever had been made in the knowledge that NH had tested positive for Hepatitis C, Dr R having been advised to that effect by my letter of 22 June 1990 (see above).

26. When I examined NH on 15 November 1990, there were no abnormal physical signs. Tests were sent for indicators of infection, anaemia, urinary abnormality, and specifically for glandular fever. Neither his symptoms nor the test results (see letter

of 27 November 1990) were in any way associated with of Hepatitis C.

27. Given his history, and his presentation during the consultation (as described in my letter to Dr R of 27 November 1990), depression was a reasonable working diagnosis in the circumstances. I therefore suggested referral for further investigations by the paediatricians. I had previously referred him to Mr Robert Milnes, the Head of the Royal Free Hospital School for advice on dealing with his problems at school.

28. The reference to the possibility that past family problems, previously noted on 5 June 1990, may be relevant is borne out by my record for the next consultation, on 24 January 1991, where the problems appear to have worsened. However my note of 17 April 1991 records a dramatic improvement, which appears to have been the result of the introduction of an iron supplement. Moderate iron deficiency had been noted in my letter to Dr R of 27 November 1990. Iron deficiency is not associated with Hepatitis C, but may be a corollary of haemophilia itself.

Section 3: Other Issues

29. I have no other issues I wish to raise at this stage, in the absence of any further documentary disclosure. However I would like to place on record that I found reading Mrs H's statement both moving and harrowing. Until receiving contact from the Inquiry, I was unaware of NH's death in 2012. I would like to offer my sincere condolences to his family.

Statement of Truth

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

Signed Dr Eleanor Goldman

Dated GRO-C