GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Tuesday 2 September 2003

44 Hallam Street, London W1

Chairman – Professor Peter Richards

Panel Members:

Dr Nihal Gunasekera
Mr Neville Harrison
Mrs Muktesh Kakar
Dr Charles Winstanley

Legal Assessor: Mr Douglas Readings

Case of:

EASTGATE, John William

(DAY TWO – AM PROCEEDINGS)

MISS JOANNA GLYNN QC, and MR A HURST, instructed by Messrs Withers, solicitors, appeared on behalf of the Complainant.

MR JAMES TURNER, of counsel, instructed by Messrs RadcliffesLeBrasseur, solicitors, appeared on behalf of Dr Eastgate, who was present.

(Transcript of the shorthand notes of T. A. Reed & Co
Tel No: 01992 465900)

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A THE CHAIRMAN: Miss Glynn?

MISS GLYNN: Sir, may I begin this morning by making one thing apparent. I have been asked to do this by the defence and I do so because it seems that, in error, and I am afraid through force of habit, I referred to myself as acting for the Council yesterday. That was in error. I am, in fact, acting for the complainant, and I am instructed by the complainant's solicitors. Of course, the complainants in these cases have the right to choose whichever solicitor they wish and the complainants in this case have chosen the solicitors who instruct me. I emphasise that I and indeed my instructing solicitors act in exactly the same way as we would do, and I specifically act in the same way as I would do if I were instructed by Field Fisher Waterhouse and the Council. I hope that clarifies the matter.

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MR TURNER: I am grateful for that clarification. I make it clear that I do not in any way seek to challenge my learned friend's integrity in her presentation of the case.

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MISS GLYNN: Sir, may I move on now to my second witness, who is referred to as Professor X in this case. It may be that you, as the Chairman, would wish to say something before I call this witness.

THE CHAIRMAN: Yes, I would indeed. I have met Professor X over the years in my past capacity as Dean of St Mary's Hospital Medical School when discussing the development of paediatric services at the Central Middlesex Hospital where he also works. I am not a personal friend, or indeed a personal enemy. I have not seen or had any contact with Professor X certainly since 1995 when I ceased to be Dean of St Mary's. Until yesterday, of course, I did not know that he was involved in the case because we only have this yellow sheet which refers to a Professor X. It is up, I think, to Professor X in the first place and his legal team, but also to Miss Glynn, to lodge any objection to me continuing either in the chair or on the Committee or both.

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MISS GLYNN: Sir, thank you for that indication. May I say two things. First of all, I have discussed the matter with Mr Turner. There is no allegation concerning the credibility or integrity of Professor X being made by either party in this case. Therefore, his credibility is not a matter that needs to be determined or will be determined in this case. I hope I may be permitted to speak for Mr Turner. There is no objection whatsoever to you, as Chairman, sitting on this case in spite of the fact that you have come across Professor X before. That is the first matter.

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The second matter is that it is very easy for the identification of such a witness to be made by either the identification of him by name or indeed by the location in which he has worked in the past. I would ask that in a case as sensitive as this the press do co-operate with not identifying him if his name should slip out by accident.

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THE CHAIRMAN: I hope the press will honour that request. Can I, on the issue of my own position, turn to the Legal Assessor and ask if he has any advice for the Committee?

THE LEGAL ASSESSOR: I would advise the Committee that, in the light of the admission there is going to be no challenge to the credibility or integrity of the

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A witness in question, nobody could possibly think it improper for you, sir, to continue as Chairman.

MISS GLYNN: Sir, I shall call Professor X now and I shall begin by asking him to write his full name and indeed the hospital at which he worked at the material time on a piece of paper that will be distributed to everyone.

B THE CHAIRMAN: Thank you.

PROFESSOR X, Sworn

[Professor X questioned by Miss Glynn, Mr Turner and the Committee.]

(The witness withdrew)

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MISS GLYNN: Sir, my next witness is Professor Zeitlin. Perhaps he could have an opportunity to arrange himself and his papers in the witness box. I do not know whether now would be an appropriate time to take a short break whilst he does organise himself. It may save time ultimately.

THE CHAIRMAN: Why not? We will continue at half-past ten.

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PROFESSOR HARRY ZEITLIN, Sworn
Examined by MISS GLYNN

Q Professor Zeitlin, what is your full name?
A Harry Zeitlin.

E Q And your qualifications?
A I have a Bachelor's degree in Physiology, MBBS, which is medicine, I have a Master's in psychiatry, I have a Doctorate from a thesis and I am a Fellow of the College of Physicians and a Fellow of the College of Psychiatrists.

Q Your title is Professor Harry Zeitlin. You are Emeritus Professor of Child and Adolescent Psychiatry at the University College London. Is that right?
F A I was Professor at University College London. I think my Emeritus title actually strictly belongs to the university, but yes.

Q And Consultant Child and Adolescent Psychiatry, North Essex Mental Health Trust, is another one of your appointments?
A I am currently appointed as a consultant psychiatrist there.

G Q I am going to ask for your *curriculum vitae* to be distributed, please, and that becomes C3. (Same handed)

THE CHAIRMAN: It will be C4 because I should have given a number to the diagram of the Professor's consulting room. That will be C3 and then this document will be C4. (After a pause) Can I correct that? The diagram is a D document.

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MISS GLYNN: Sir, there were two diagrams produced. Mrs A produced a diagram, which I think should have been C3, and Professor X's diagram C4, and this one C5.

THE CHAIRMAN: Yes. I asked for the diagram of the consulting room which she had not given to us, and so I do not know whether it is C or whether it is D.

MISS GLYNN: It may be easier to give it a C number running sequentially, unless

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Mr Turner objects.

MR TURNER: Of course.

MISS GLYNN: Thank you. I shall ask for photocopies of Mrs A's diagram to be distributed.

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THE CHAIRMAN: Can we get it quite clear? The diagram that Mrs A produced of the arrangements in the consulting room is C3. The diagram that we were given by the Professor is C4, and these documents which we have just received are C5. I am sorry that I was confused.

MISS GLYNN: I shall arrange for copies of the diagram produced by Mrs A to be made and to be distributed.

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(To the witness) Turning to C5, Professor Zeitlin, your *curriculum vitae*, we can see your full name and your training and your current post described there. You set out your current clinical involvement under a heading there. You are senior consultant to a service providing for a population of approximately 300,000 in West Essex. Referral of approximately 1000 per annum, include all forms of emotional and behavioural disturbance. Clinical range relevant to expert witness work including

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clinical problems such as depression, psychosis, anorexia, substance abuse, PTSD – what is that?
A Post traumatic stress disorder.

Q ADHD?
A Can I make an apology? I have a slight cold this morning, so if I become inaudible please could I be told?

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Q Yes. ADHD?
A Attention deficit disorder.

Q Family and social problems, such as child abuse, parental separation and divorce, and learning and educational problems such as developmental delay, school refusal, and bullying. Over the page you describe committees, associations,

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affiliations, previous appointments, current research, and then on the third page there is a heading "Selected Papers and Publications". There are a number of those. I am only going to highlight ones that may be of some relevance to the subject-matter of this case. The fourth item, 1987, "*Assessment of Sexual Abuse of Children*" in *The Lancet*. Further on in the list you published with Kolvin and others a paper in 1988, which in fact is in the literature bundle. Is that correct?
A Yes.

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Q We will look at that later. Then a document next in the list, December 1988, published by the Royal College of Psychiatrists, called "*Child Psychiatric Perspectives on the Assessment and Management of Sexually Mistreated Children*", a report of the Royal College. Then a publication in 1989 called "*Writing a Court Report*". What was that about, briefly?

A I have been involved with medico-legal work since 1974 and I teach on this. We have an annual course at the Royal Society of Medicine, so it is an area which I particularly look at and try to share my expertise, whatever that is, with trainees.

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Q Did that document have anything to do with the assessment and referral of child sexual abuse cases, or not?

A Not specifically.

Q Then the next one, in 1989, "*Primary Care and Referral for Suspected Child Sexual Abuse*". Is that another one of your publications?

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A Yes.

Q There are various other publications and then, at the top of the next page, the second item in the list is a publication in 1995 "*Sexual Abuse of Children, In Community Child Health and Paediatrics*". You have provided various other pieces of information about your expertise.

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I am going to move on, if I may, to the subject-matter of this case. You have described your qualifications and your experience briefly in that *curriculum vitae*. This case, of course, concerns a 13 year old girl – although she was a little younger than that when the subject-matter begins – who, due to a suspected overdose, whether or not it was, was admitted as an in-patient to a hospital in Wiltshire. Can I ask about your experience, your direct day to day, hands-on experience of dealing with children who are very disturbed, depressed, perhaps self-harming, that sort of situation?

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A Numerically, I probably could not tell you. Our district receives approximately 1,000 referrals a year. There are inadequate resources and therefore the filters remove the milder problems from the referral from the assessment system. I would be regularly dealing with very disturbed youngsters, with youngsters with whom there is a suspicion of abuse on, I would say a week by week, but probably day to day, because a lot of my work outside the health service now involves the assessment of people who might or might not have been abused, for legal purposes. So I would say on a day to day basis. I also, of course, supervise and still do supervise junior staff who would be involved in the same work.

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Q What about your experience of children in this disturbed state who make allegations of sexual abuse?

A Currently I do not run an in-patient unit and therefore meeting with youngsters of this age in an in-patient unit, no, I do not now. I did at one time, when I ran an in-patient unit at Westminster Children's Hospital. Looking at the issues and criteria and nature of the probability of abuse is something that I regularly advise on and have to be familiar with current thoughts and concepts concerning that. I was involved last week with a youngster where there has been an issue about previous allegations of abuse. It is that much part of my current work.

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Q You have compiled various reports that you have produced in this case, and I should say that I am not going to produce, for the time being, any of those reports. We are going to deal with this witness through live oral evidence for the time being. Before you compiled your reports, Professor Zeitlin, you had access to a large volume of material, hopefully all the relevant material in this case. Is that right?

A I have no idea if it is all the relevant material. I had access to a large volume, seven volumes plus additional papers, making two further volumes.

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Q I think you have spoken to Miss A's parents and, indeed, Miss A. Is that right?

A I have interviewed Miss A's parents on one occasion and Miss A on two occasions.

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Q This is a case in which Miss A had been referred to a professor of endocrinology for reasons of her excessive height and you are aware of the details of that referral, and indeed, I think have seen the notes relating to it. Is that right?

A I have seen the notes that have been given to me, yes.

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Q Could I ask you simply one question about that? We know that Miss A was prescribed oestrogen as a treatment for her excessive height. What effect can oestrogen have on mood, if any?

A Certainly there is evidence about the relationship between the menstrual cycle and mood. I actually did a literature search, as is my normal practice, to see if I could find any clear link between the induction of precocious puberty, and actually could not find any articles that are written to do with the oestrogens. Therefore, I do not have clear evidence linking that under these circumstances. I do have experience of children who have had precocious puberty for a variety of reasons, or early puberty for a variety of reasons, and it is certainly my clinical experience that emotionally that is quite difficult for the children I have seen. I do not know about the children I have not seen. For the children I have seen there is a difficulty in handling the fact that they have become pubertal prior to other children, and some of the issues that surround that.

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Q You are aware that in February 1996 Miss A was referred to Dr Treasure, a consultant psychiatrist, at the Eating Disorder Unit at the Maudsley Hospital, and she reached what was, as I understand it, in your opinion, an understandable view that Miss A was showing early anorexia nervosa?

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A I am sorry, I am not quite sure what your question to me is.

Q Is it right that it is your view that it was understandable that Dr Treasure, in the circumstances, should reach a diagnosis of Miss A showing early anorexia nervosa?

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A Yes.

Q We then know from the records that Dr Eastgate became involved with the care of Miss A and his diagnosis was that she was suffering from clinical depression rather than anorexia nervosa. As I understand it, that again, in your view, was reasonable on the criteria given by Dr Eastgate?

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A Yes. Dr Eastgate in a letter specified the criteria, gave an explanation for that, and it seemed quite appropriate. It seemed to me to be appropriate and in line with normal practice.

Q Can I ask you now, please, about severe mood change in young people. Is it always the case in your professional experience that severe mood change occurs with a specific cause or might it occur without any specific identifying cause?
A You are asking a very generic question when you refer to mood change as opposed, I think, to what I referred to in my various reports, where I referred to clinical depression. Not all mood change is linked with depression. Would you prefer me to answer with regard to mood change which in pubertal teenagers is extremely common, with quite a lot of other emotions involved. If we are talking about clinical depression that is ---

Q Let us take it in stages. Mood change, first of all, you have said is very common in pubertal girls, or indeed boys?
A Transient, short-term, severe mood changes have a variety of explanations but very much to do with the move from a childhood status to one of more independence, with lots of uncertainties, lots of turmoil and it is my opinion quite linked, also, with the hormonal changes. I have explained why I say that is my opinion. The literature is less concrete on that.

Q You are going on to explain there is a distinction between mood change and depression?
A Clinical depression requires a change from a former state, evidence for sustained depressed mood. A child who is miserable in the morning and out dancing in the evening may appear to show just as severe mood depression in the morning but is not likely to be suffering from clinical depression. We could argue one or two possibilities round that but normally it would require change, a sustained depression of mood for at least a couple of weeks together with evidence for dysfunction. I am sorry – I do not want to get into a lecture about it but one would have to point out that those were the three particular ones. The change from former status is slightly more complicated but sustained depression of mood and impairment of function.

Q Could I ask you about self-harming? A child who is seemingly cutting herself with scissors, or trying to – that sort of self-harm: what would you say about that? Is that something which can occur without a specific pause or it is something which would occur with some sort of cause?
A If one looks at children who self-harm, some of those children, possibly a majority, will have an identifiable association of some sort. Deliberate self-harm, apart from suicide or suicidal behaviour, is less specifically linked with depression and is more linked with what one would describe as dissociative disorder. Indeed, we have done some research looking at whether this is the underlying mechanism – association. There is an association, at least a described association, between abuse and deliberate self-harm. Whether there are other possible causes is much more debatable but, for example, a common one and a known one is that if you have one child in a social group who self-harms, you are quite likely to get an epidemic of it.

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Q During your examination of the papers in this case, can we establish whether or not there was any other self-harming evident in that hospital at the time on the part of other children?

A I would have to say, I would have to go back to my notes. My recollection – and I have to say, I cannot say if this is correct – is that there had been, but I would be ---

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Q We will come back to that later.

A That, of course, is not central to the issues that I have been concerned about.

Q The topics that you have been giving evidence about are the issues of mood swing, of depression and self-harming. If you were treating a child who was showing symptoms of that sort, would you be looking for a specific cause or causes for that behaviour or not?

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A I would normally seek to identify whether there were possible causes, partly from a treatment point of view, but also partly from a future prevention point of view. The risk for future depressive episodes is quite high once a teenager has one episode. Therefore it would be normal practice to start to look and say, "Are there any other causative factors which one could work with in order to reduce the future risk?" It might help in dealing with the current episode, both in terms of the reasons for the depression but also the reasons for distress. You do not always... I am not sure I would want to put a figure on it, but in a proportion of youngsters you do not find an identifiable cause. There may be one, but you do not find an identifiable cause.

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Q Before we move on to the notes, and the specific events with which this case is concerned, we know that this patient was prescribed amitriptyline. If I may lead you on this, as I understand it, your opinion is that that is a good antidepressant that was used extensively with young people until the advent of the SSRI group. Is that right?

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A Yes.

Q And appropriate too?

A I do not know if the Council is aware that there has been a controversy about the effectiveness of antidepressants in teenagers over the last few years. It still remains my opinion that it is an effective antidepressant if you have a clear depression. In fact there is a move now back to the tricyclics because of problems that have arisen over the SSRIs, but I do not think that is central to this. It was reasonable, in my opinion, to prescribe ---

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Q Reasonable at the time to prescribe ---

A ---- an antidepressant, yes.

Q Moving, if I may, to the events that are central to this case, we know that Miss A was admitted as an inpatient on 13 June 1996. We have notes compiled by Dr Eastgate. That is tab 2 of our bundles. Those notes concern the consultations with Miss A. Do you have tab 2 there, Professor Zeitlin?

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A Yes, I do.

Q Could I ask you about the note headed "End of May 1996" at page 2? There it appears that there were a number of specific things that were problematical for

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Miss A. There appeared to be a problem with her relationship with her mother. Is that right?

A Sorry? You asked me ---?

Q I am simply adducing this through you, if you would not mind?

A "... three things Miss A does not like – Mother, [Miss A's sister], and home."

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Q Yes, that is right. And the younger sister and home, and there is also reference there to the death of B as being significant. Is that right?

A Yes.

Q And also there was talk on that occasion about horses, and her father's definite views, which conflicted to hers, and led to her finding a horse which she had become very fond of being sold without her knowledge. That is what she was telling

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Dr Eastgate at the time. There is further reference to B later on. At this stage, the problems are mother and younger sister, B and the issue about the horse – on the face of it?

A That is what is reported here.

Q Then, as we turn through the pages, we can see the notes. I am not going to go into any details about these because the Committee have them before them, but on

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page 4 there is a note for 18 June. The second paragraph:

> "Key issues remain the illness and death of B who was a very close friend, and, as best I can tell, this was an important and positive relationship, much complicated by the way in which news of B's illness and death were handled."

And there is reference to a rather poor relationship with her father. Then on 6 July,

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page 6, there is reference to her talking about how things go wrong, specifically B, the retirement of the headmistress in the school, and somebody else "but she couldn't tell me". Then, on the day before the central allegation in this particular case, namely 8 July, there is a note there referring to a session with Miss A and, indeed, Mrs A. There is reference there to her sometimes being quite angry with her other and unhappy when her mother cried because she felt this was unhelpful, particularly as she had been told how much she was making her mother cry. There is reference to

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her sitting on the floor, which her mother found a bit of a challenge. That is the context, if I may put it that way, when we reach 9 July, the key date in this case. Is that right?

A That is the report from Dr Eastgate's typed notes. The composite picture that one gains from going through the file to this point is of a girl who is miserable, who can be unhappy, who can be very angry, who has an ambivalent relationship with her parent which is a close one, but also with a lot of hostility and anger. It is not

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uncommon. It is my understanding from having gone through the notes that there was a question about the distance that she felt her father had from her, so this is the picture if you are asking me what is in here when you read it out. If you are asking my impression of this girl at this point, that would be the more accurate one of the impression that I have gained from the files.

Q One of the words you have used in your reports is "wilful". Is that right?

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A That is the impression that I gained, of a girl who would be quite angry and want what she wanted.

Q What do you say the relevance of that assessment of the patient is?
A First of all it is important to have some idea of the character and the nature of the child if you are going to understand, if you are going to interpret, the behaviours that you then observe. There is a very big difference between a child who is a quiet, passive child, who then develops anger or a child who has been angry. It is, for example, relevant, if I may raise a point that you have not actually asked me but it is relevant to this. If, for example, there is prior to that date a note explaining her anger towards Professor X. There is a note that she was moderately averse to the other consultant. I presume that it is better for me not to use any names at all under these circumstances?

THE CHAIRMAN: Please.

THE WITNESS: She had seen another consultant as well and there is a note saying that she was angry there, so there is character here; not that she cannot be loving and sensitive, but there was a pattern of a girl who could readily be angry, maybe for a variety of reasons.

MISS GLYNN: I am going to ask you, please, to turn to the note for 9 July 1996, at page 7. We can see that this note refers to the morning session with Miss A. There is no indication of when this note was made – is that right as far as we can see?
A Before I proceed with this, do you mind if I just make a statement about my own position with regard to this? I think it is important as it may appear that I am being critical. When I was first asked, I pointed out that I would make an analysis of the data that would be exactly the same whoever asked me for that opinion. It is not in any way setting out to be critical of Dr Eastgate. It is meant to be an unbiased critical analysis of the data. Can I make it quite clear that that is the position that I am taking.

Q Yes. As I understand it what you are saying is that you are seeking to be wholly objective?
A I was not seeking to find fault. I was seeking to analyse the data that was presented.

Q Can we proceed to establish what your views are about the data that has been collected? We see the note for the morning session for 9 July: this is clearly a crucial note and I want to go through it in some detail with you, if I may. The note begins:

> "Again [Miss A] very withdrawn, not talking. I talked to [Miss A] about her Saturday discussion that it felt there were people who had let her down, people who she talked to or had made promises...".

Pausing there, it may be appropriate, sir, to highlight that because that appears to be the topic – people who had let her down, people who she talked to or had made promises.

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> "...who somehow or other had then gone away. I talked to [Miss A] about the time she told me about the family ponies and difficulties she has had with her father's different views regarding these animals, I talked about B and [the headmistress], and then reminded [Miss A] she said there were more people. [Miss A] very withdrawn and quite watery eyed at this stage.
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> I asked [Miss A] how many other people she said one. I asked whether adult of child, and after a lot of hesitation [Miss A] said adult – Male or female? And again a lot of hesitation before Miss A said male in a whisper..."

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Pausing there, do you have any observations about the contents of this interview with Miss A, subject to the fact that we are relying entirely on Dr Eastgate's note here?

A At this point it appears that there is a pressure for the girl to continue with some leading but relatively open choices. For example, "male or female", there is not another choice, so that is a perfectly good question. To this point it does appear that there is an attempt to pursue things that are happening. One would wonder this is being pursued in this sort of way at this point in time because previously it was to do with being let down and to do with loss. At this point it appears that the interview, as reported, is relatively neutral in its questioning.

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Q Is there anything inappropriate about it at this stage?

A I would say that it was acceptable within the range of techniques to that point.

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Q Proceeding, if we may, the next question appears to be:

> "Was it family? – No it wasn't – Was it somebody [Miss A] had known a long time? – No it wasn't. Was it somebody in T? – No – Was it somebody at [her junior school]? No – Was it somebody at [the boarding school]? – No – Was it somebody in London? – Silence."

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Pausing there, what are your observations about what appears to be the technique of interviewing at this stage?

A Well, it is a little difficult to understand as reported as to what the purpose is. It appears to start with enabling her to talk about people who have let her down. "I talked to Miss A about a Sunday discussion, it felt that there were people who had let her down". This now appears to be making a shift into seeking something more specific. The introduction here as to whether "it" was, at the moment there is not an "it" that one is trying to identify. Nonetheless, there are questions now specifying areas. There are questions now specifying locations and the nature of the interview appears to be changing, as reported.

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Q Changing in what way?

A To become more specific, giving areas for the child to focus on. I would still say it is probably still within the range of what might be acceptable. There is a change in the character of what is reported here.

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Q But probably within the range of what is acceptable. Moving on to the next paragraph:

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> "I suggested to [Miss A] that I guessed it sounded as if it was somebody in London. Given that it was neither family nor school, and it was clearly somebody else, I wondered if perhaps it was somebody medical, and [Miss A] agreed that it was."

Pausing there, what do you say about that passage?

A This is quite a radical change. The key point – and I must say it was reported, and I think it is reported here in good faith – the key words are "I suggested".

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Q What do you say about that?

A This is putting a proposition, a very specific proposition, particularly bearing in mind that a proposition like that could only refer to a very limited number of people.

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Q What do you say about the suggestion that perhaps it was somebody medical?

A This is the point I have just made, that that actually makes a suggestion or proposition that could only relate to very --- If one says, "Could it be somebody in T?" T probably has a population of God knows what. Here it is becoming very specific and actually suggesting that the words are used, "I suggested to". There is a proposition being put to the girl which could only have a very limited answer from a very narrow range of people.

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Q So far as you are able to assess had there been any suggestion before this made by Miss A herself that she had a specific problem with a medical practitioner?

A Yes, there had been. It is known throughout that she was very angry at a particular – it is known that she was cross and angry with a particular professional who has given evidence. Indeed it is referred to Dr Eastgate's letter of 22 February where he says ---

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Q 22 February?

A Yes, a long time before, where he says:

> "Because he felt there was a tendency to development polycystic ovaries he made the comment to [Miss A] that she really should not become too heavy and [Miss A] was rather offended by this."

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Q Which page are you looking at?

A I am sorry, I am looking at page 2, tab 1.

Q This is the general practitioner's letter.

A I apologise – yes.

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Q It is the general practitioner's letter to Dr Treasure.

A Yes.

Q So the problem that was being identified then was that she was offended about a reference to her weight?

A Yes. There is, of course, another reference on 25 April, and the letter starts off "When [Miss A] was rather negative towards me". When you are saying, "Was there

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A a problem?" yes, there was a problem, but one which appeared to be identified with an identifiable cause.

Q The note proceeds:

"I asked whether it happened once or a number of occasions ..."

B What would you say about that?

A This again is quite a radical change from the spirit of the previous discussions and the start of this interview. Where it starts is with resentment and a general attitude. "It" now appears to be, and it is my view it could well be interpreted as or is likely to be interpreted by the child, as an event.

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C "[Miss A] said happened on a number of occasions. I wondered which clinic, given that it was a male doctor. I am aware that [Miss A] has only seen one male doctor regularly and that is Professor X. [Miss A] agreed this was the case."

Pausing there, what do you say about that passage?

A Well, it is a little hazardous to take sentences out, but in fact what it does

D suggest is that, having introduced this theme and suggested it, he was actually aware of whom he would actually be referring to. In my view that is hazardous.

Q I am sorry?

A It remains my view, as I have given the opinion, that that is quite hazardous.

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E "I asked [Miss A] when she first saw Professor X. [Miss A] said when she was eight. I then asked [Miss A] when she first felt uncomfortable and [Miss A] said when she was nine. – This was her second appointment, she cannot remember much about the first appointment. [Miss A] felt her parents wanted her to stop growing, she was not so bothered. The appointment appeared to go OK. The second time she went with maternal grandmother – [Miss A] declined to talk further about what had happened but made it clear

F that she had a very unhappy experience at this appointment. I suggested to [Miss A] that I see her again shortly to talk about it further."

What do you say about that part of the note?

A As you pointed out, I have a very large volume of notes. I could not find any previous reference to the girl talking about feeling specifically uncomfortable. There is anger, there is resentment, there is clear evidence that she did not like the person

G concerned, but this is introducing a second element, or it is another element. There is the person, there is reference to "it" happening, and now we have reference to "it" being her being uncomfortable.

Q What do you say about that in terms of its appropriateness or otherwise?

A The position at this point would be as to whether the doctor had been forming the opinion that something untoward had happened. If he did not, it becomes more

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difficult to explain the nature of the questioning, and I am afraid, if he did, he would have been aware of the need to avoid as much direction and suggestion as possible.

Q Why do you say "he would have been aware"?
A If you know the reason that he points this out to members of staff later on, but it is my opinion that it would have been known practice from all the guidelines that one avoids anything that would be leading under those circumstances.

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Q I think the reference that you have made to him pointing it out himself is to 16 July, bottom of page 10, where there is a passage in the note written by Dr Eastgate:

> "But at the same time it is important that all discussions whether with nursing staff or other clinical staff, are written down as nearly verbatim as possible, and that no leading questions are used in trying to elicit information."

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Is that the passage you are referring to?
A I am pretty sure it is. Yes, it is what I am referring to.

Q Before we look at what happened in the afternoon, could I ask the Committee to take up the literature bundle, please. Do you have the literature bundle there, Professor Zeitlin?

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A Yes.

Q I am going to ask you to look at two passages. The first is in tab 1, which is *Jones*. Before we turn to it, you should have an index at the front of the bundle. Do you have that. Can we look at what we have in this bundle and familiarise ourselves with it and the dates particularly of the publications. *Jones, "Interviewing the Sexually Abused Child"*, published by the Royal College of Psychiatrists. It was published in 1992. I think there was an earlier edition – is that right?

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A There were a number of editions. I think that the 1992 one is the nearest to the date.

Q I think it has been established that the 1992 edition was the nearest in date to these events?

F

A Yes.

Q But there were earlier editions?
A There were earlier editions. I think there has been a later one.

Q How well known was this publication, *Jones*, and I hold it up <u>here</u> so that you can see the document we are looking at. How well known was this publication?

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A I would have expected that to be standard reading, certainly for most trainees. I would be very surprised if any psychiatrist did not know of that publication. It is a Royal College of Psychiatrists publication. As far as my memory tells me, it is Gaskell Press and the Royal College of Psychiatrists.

Q Yes. The second document we have in the literature bundle at number 2 is a paper which has been referred to as *Kolvin et al, "Child Sexual Abuse: Principles of Good Practice"*, British Journal of Hospital Medicine, January 1992. We can see, if

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A we turn to the front of the document, that you indeed are one of the authors. Is that right?

A Yes. I do need to point out that Professor Kolvin, myself and Dr Jones were the independent panel at Cleveland, psychiatrists, not paediatricians, the individual panel at Cleveland.

Q You were part of the independent panel of the Cleveland inquiry?

B

A Yes, we were the psychiatric input.

Q We can see that at the top of this document it states "Prepared by the Independent Second Opinion Panel, Northern Regional Health Authority, October 1987, and submitted to the Cleveland Child Abuse Judicial Inquiry". This has been included in the bundle of literature for what reason? Was it well known, this document, amongst psychiatrists or not?

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A Yes, I think at that time, my memory tells me that it was published in the *Journal of Hospital Medicine*. It is probably easiest to explain why Cleveland was important. It very publicly aired the issues concerning the assessment and manner of examining children for whom there might be a suspicion of abuse. That was then very publicly aired and discussed, and certainly over the succeeding ten years – this is 1987, the Cleveland inquiry I think closed at the end of 1986 – there was a decade of detailed discussion about guidelines and appropriate methods of examining children.

D

It was not just Cleveland and where it had wrong. There was the Orkneys, Birmingham, Manchester, there were a whole host. There was a major public airing of the techniques and the errors and fallacies that could arise. One could discuss why it had arisen in that sort of way and why people had been led into wrong ways. There was a very public airing over a decade.

Q This, as you are stating, was a very much live topic from, say, 1988 onwards,

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and resulted in a number of publications – is that right?

A From a variety of people. It involved the judiciary.

Q Referring, if I may, to *Kolvin*, tab 2, how widely distributed and read was this by people in the field?

A I am not an editor and a publisher and I have no idea whether Dr Eastgate would have read it, but I would have anticipated it to have been read by most people

F

because it was the definitive publication referring to the issues which had arisen out of the inquiry, but more specifically about producing appropriate guidelines.

Q Proceeding briefly, if I may, through the bundle so that we can see what is there, at tab 3, *Diagnosis of Child Sexual Abuse"*, this is the HMSO publication published by the Department of Health and Social Security, *Guidance for Doctors*, published in 1988. What do you say in general terms about this document?

G

A These again were some of the guidelines. They were extant at that particular time. For example, this document refers to one of the editions of the other book that you are referring to, *Jones and Quiston*. The relevance of this is that it was an important contribution to the systematising advice and guidelines to doctors to deal with some of the errors and problems that had arisen and resulted in a variety of inquiries around the country.

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Q I would ask you, as I did with the other documentation, as far as you know, was this required reading by people practising in the field or not?
A I would expect it to be required reading or at least for any doctors to be familiar with the recommended guidelines.

MISS GLYNN: Sir, behind tab 4 we have *Working Together*. If I may explain the way this has been put together, it is a rather intimidatingly huge document, but in fact there are two editions here, in case passages from one are relevant which are not found in the other. At the front of your tab you will find the 1992 edition, and it may be worth writing that on the front page, because it is not very easy to find that date – you will see that copyright is 1991. That is the 1992 edition of *Working Together – Under the Children Act 1989*.

B

THE CHAIRMAN: The first page we have says 1989.

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MISS GLYNN: That is "*Under the Children Act 1989*"; the publication in fact is 1992.
A The date on the next page that I have is 1991.

MISS GLYNN: Sir, you will find a divider – in my bundle it is green, but I do not know whether it is green in yours or not. It is headed "Addendum". A little further on, about an inch-worth of paper into the document, it says "Addendum", and that is the addendum to the 1992 edition. Then about half a centimetre worth of paper further on – sir, I am afraid the page numbers are not very easy to identify – the addendum begins after page 126 – if you turn to page 126, the pagination at the bottom left-hand side, you will then find the addendum to the 1992 edition.

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THE CHAIRMAN: Right.

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MISS GLYNN: After that addendum, which is 23 pages long, you will find the 1988 edition. It might be worth putting in some Post-it notes to divide them up, because we will be referring to the addendum later.

THE CHAIRMAN: Did you say 1998?

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MISS GLYNN: 1988. That comes immediately after the addendum, and it is called *Working Together. A guide to arrangements for inter-agency co-operation for the protection of children from abuse"*. You will see on the second page "Crown copyright 1988".
(To the witness) Briefly, Professor Zeitlin, can I ask you about the importance of this publication *Working Together* in the context of child abuse and psychiatry?
A I would actually point out the importance of the bundle of documents, and that is that there was quite ample documentation as to guidelines that were available from a number of sources, and one question that one could raise is, is my opinion simply that everyone would have known because I knew at the time, because of my involvement? But there are quite wide-ranging documents giving guidelines – rightly or wrongly, whatever they were – but certainly giving guidelines on specific issues about the investigation, management and the handling of cases where there had been suspicion of abuse.

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A Q *Working Together*, was that required reading for people working in your field at the time?
A It was certainly required reading for anybody working within my training that I was giving, but I would expect – the difficulty is that you are asking me to have knowledge of all the reading lists for all psychiatrists. I would say with confidence that any practising psychiatrist should be aware of at least some – and I would think actually all – of these guidelines. It was such a well-aired issue.

B

Q Then at tab 5 we have the GMC guidance published in October 1995; at tab 6, the Annual Report of 1987; tab 7, the Wiltshire guidelines – and we will come back to look at those documents in due course. We have been looking at the morning session on 9 July 1996, and you have been providing the Committee with your professional opinion about the interviewing technique. Could I ask you to look at tab 1, which is Jones, the 1992 edition.

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(To the Chairman) Sir, I should explain – the whole publication has not been photocopied for you. If further pages are required by the defence they can certainly be inserted.

(To the witness) With reference to the evidence you have given already about the interviewing technique, could I ask you to turn to page 45, which you will find

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photocopied immediately behind the front cover of the document. They are not in page order; the Jones documents are photocopied in the order in which we are going to adduce the evidence. Page 45 is the first one you will come to, and there is a heading at the bottom left-hand side, "Gathering specific detail".
A Yes.

Q

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> "If the child has been given an account of [child sexual abuse] in outline, more details will often be required so as to lessen the need for further interviews. Following the child's lead by allowing her to give her story at her own pace, with her own words, is the key issue at this point. Caution should be exercised here to avoid the use of suggestion or any leading form of question, ..."

Is that something you agree with?

F

A Whether I agree with it – I certainly do agree with it, but whether I agree with it or not, that statement appears in some form or other in the majority of documents giving guidelines.

Q Could I ask you to turn to *Working Together*, tab 4, the 1992 edition – in other words, the one that is photocopied first behind tab 4 – and to turn to page 30, paragraph 5.14.7. There is a reference towards the end of that paragraph, about six

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lines up:

> "He or she" –

referring to the interviewer –

H

> "must work at the child's pace and use language that the child can understand and thus enable the child to talk about and give as clear an account as possible

A

> of events that have taken place. The interviewer must always be open to the possibility that the events have not taken place."

That is the view expressed in that document there. Can I move with you, please, to the session that took place in the afternoon. Before we look at the note for that, given what appears to have been said by Miss A that morning, what would you expect the psychiatrist – Dr Eastgate in this case – to have been concerned to ensure by the time of the next session?

B

A You are obviously asking me for something which I have given an opinion on in any case. Once there is a suggestion that there could have been inappropriate behaviour towards the child, then certainly it is extremely important to avoid leading the child in any way at all. Secondly, it is extremely important not to convey an opinion to the child. Concern and an opinion about the nature of the actions are not the same thing. You can express concern, but not an opinion. And, thirdly, to have

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made sure that there was detailed verbatim – and to use Dr Eastgate's own words later on, word by word – recording.

Q If we turn to page 8 of tab 2, C1, Dr Eastgate's file notes, Dr Eastgate's name appears at the bottom of that page, and that page appears to encompass notes of sessions on the afternoon of 9 July, the morning of the 10th, the afternoon of the 10th and the morning of the 11th; is that right?

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A Yes.

Q Looking at the note for the morning of the 9th, the note in total comprises five lines and three words, and it reads:

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> "In this session [Miss A] moved on to talk about how at 9 her breasts were stroked by [Professor X] and he touched her in other intimate places. This felt uncomfortable and wrong, but she didn't know what doctors were supposed to do. She felt she was probably responsible for what had happened. She was surprised when I suggested" –

and it would appear that "not" is left out there –

F

> "that [not only did it sound wrong to me but I was worried that he may have done it to other children as well."

What do you say about that note?

A I could refer back – I think it was in the Jones document – that one should avoid transmitting an opinion to the child. It is my understanding that there are no detailed notes of that interview. Dr Eastgate does – and I say this – perhaps I would need to qualify this and say that it does appear that he was acting in good faith, but

G

here is an opinion given to the child, and there are no detailed records of that interview. It is my understanding that by that point he was quite definitely concerned about the possibility of abuse. Indeed by the 11th, the note on the same page refers the note refers to "the abuse".

Q What do you say specifically about his reference to it sounding wrong to him, and being worried that "he may have done it to other children"?

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A There is a very specific reference. It is endorsing to the child that something has been done wrong. It is no longer in any way an open interview, and there is unfortunately a high likelihood of influencing the child's perception of what she has said and is saying.

Q In what way?
A We need to come back and say this is an angry, resentful, miserable, unhappy child, who might well be looking for justification for her feelings. It may be that something untoward had actually happened, but once you transmit an opinion like that, which is, I have to say, different from saying "Go on, I am concerned" – this is much, much – this is quite different. There is a high risk of influencing the child so that it becomes difficult to interpret what the child says.

Q What would have been an appropriate technique in these circumstances?
A There are a variety, and all the indications are to ask, as was happening before, much more non-specific questions: "Go on", "I am concerned", "Please explain to me", "I'm not sure I fully understood", "It's OK, tell me what happened". Even saying "It's OK", you might say that could be misinterpreted, but one would want to say "It's OK for you to tell me". But that is a very specific statement, with a very clear indication, and the statement that "It could be done to others" gives a very definite opinion to the child, in my opinion.

Q How would the child, in your professional opinion, see herself thereafter? In what role?
A The risk is that if you assign a child a victim role, that that perception of the child may continue. I have to say it may not, but that is the difficulty, and that was the difficulty that had arisen in a variety of circumstances, not that it would have caused – and I listened to the discussions about causality yesterday – not that it would have caused what followed, but it makes what followed extremely difficult to interpret.

Q You referred to "muddying the water".
A That is a phrase which I used in my various reports, and I think was in the composite report which was prepared. It is actually a term that I had previously heard used by a High Court judge in a case where this had been an issue.

Q Could I ask you to turn to Jones, please, at tab 1 of the literature bundle – the second page behind the front sheet, which in fact is page 15, although you will probably find that the top has been cut off; it has in mine. This is page 15 of Jones, but they are to in page order, Professor Zeitlin; you will find it is the third page copied.
A Yes.

Q At the bottom of the page, the last paragraph begins:

> "All the experimental studies have underlined the harm that can be done by leading techniques in the questioning of children. What are the possible distortions in children's memory?"

A

Then there is a reference to a publication there. You referred to the child potentially taking on the role of victim, and you also referred to the fact that by 11 July the note refers specifically – at the bottom of page 8 – to "Still thinking about the abuse."

A That also appears, incidentally, in the nursing notes.

Q Can you turn to the nursing notes at tab 3, page 7?

A May I make reference, before I take my thumb out of this, because on the preceding page Jones says:

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> "One has to be cautious to modulate one's own emotional response",

the top left-hand corner of the page before the one you have just been quoting. I thought that was the reference you were making originally.

C

Q Page 14?

A The top left-hand corner of the third page in Dr Jones's document that I have, the third line down:

> "One has to be cautious to modulate one's own emotional response."

I am only picking that out because it is very specific.

D

THE CHAIRMAN: Which page is this?

A This is page 3. It is tab 1 in my bundle, the third page. The first one ---

MISS GLYNN: It is page 46.

THE CHAIRMAN: So it is page 46 in the document.

E

THE WITNESS: I am raising that because it has direct reference to the questions you have just asked me.

MISS GLYNN: Can I consider the interviewing techniques on 9 July in the following context. If Dr Eastgate had suspicions that this child had been abused, was the way he interviewed the child appropriate or not?

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A If he had suspicions that the child had been abused then he should have been both extremely cautious about using any leading technique. I point out that is different to encouraging the child to continue. He should not have transmitted any opinion to the child and he should have kept detailed verbatim notes.

Q If he did not have any suspicion that the child had been abused, was his interviewing technique appropriate?

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A I would find it very difficult as to what is being referred to in the terms of "it" happening several times. I would also point out, because in my view I need to be as careful as I possibly can, because of the circumstances, that the picture I get is correct. You see, by the 11th there is reference to "the abuse", but my understanding is that there still is no verbatim account. So even if one could be in doubt about the 9th, by the time we get to the 11th it is quite clear; but there is no verbatim account.

H

Q What do you say about that?

A One can look at it both ways in saying maybe on the 9th it was still general. I think the issue is for the Council to consider this, but if it was still general one might say, well, maybe there still was not an imperative to keep detailed notes. One always should, but still. But if that is the case, it still becomes difficult to understand why, when it is absolutely clear that there is an issue of abuse, there was still no verbatim account. It is my view on the afternoon of the 9th that it is fairly clear from the notes, and I say again, to Dr Eastgate's credit, that he has recorded the spirit of the overall content, not the detailed notes. But it seems fairly clear to me that by then he was concerned that something inappropriate had happened and he refers, indeed, to the child talking about her breasts being stroked.

Q I am going to ask you some specific questions now about verbatim records and the requirement for them. You have given evidence about the period after the allegations first came to light on the morning of 9 July. Could I ask you to turn, please, to the literature bundle and we will look at some extracts that relate to this topic. First of all, could I ask you to turn to "*Working Together*", which is tab 4. It is page 4 of the addendum, paragraph 2.10.
A I am sorry, my addendum has only one paragraph 2 and that is 2.1. (After a pause) 2.10, yes. Sorry, the numbers are slightly difficult. It is starting "Comprehensive contemporaneous records…"?

Q Yes.

> "Comprehensive contemporaneous records are essential as they are the best evidence of any discussion or consultation. In making these, doctors must bear in mind the patient's legal rights to access medical records and reports and the possibility that reports will be needed later in court proceedings."

Can we turn to the main body of "*Working Together*", paragraph 5.9? Do you have that, Professor Zeitlin?
A "The importance of recording at all stages…"?

Q Yes.

> "The importance of recording at all stages of the child protection process cannot be overemphasised. Evidence from reports, enquiries and reviews into the deaths of children indicates the vital importance of good record keeping."

It may be suggested that when interviewing a child about a sensitive topic, such as whether she has experienced something that has made her uncomfortable, it could be off-putting to be writing contemporaneous notes at the time. What do you say about that?
A Yes, it could be off-putting. I have to say it is probably easiest to refer to my personal practice. I normally keep contemporary notes. I say to the child: "Do you mind if I write while we talk?" If there is an area which comes up and I am writing and I think this child is going to find difficulty, I would put my pen away. I would then immediately record from memory, as quickly as I could. It may be said that not everybody would keep word by word notes, but in fact those are Dr Eastgate's words to his staff, to keep word by word verbatim accounts.

A

Q You are referring to the 16 July note?

A I could find it for you, but I am sure that is correct. The point is that one might say in normal practice there may be a variety of styles. Certainly these days – these days, for at least a couple of decades, I have been advising all people training in this field that they must keep detailed notes, if for nothing else, for their own protection. But under these circumstances all the information appears to be quite clear, all the advice. It is not just my opinion. There is, as you have pointed out, clear good practice direction to keep verbatim records and I am afraid that this was even pointed out by Dr Eastgate himself a few days later.

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Q I am going to move on to Head of Charge 6.

A I am pointing out that the reason for going into this in quite that sort of way is because, in going through the accounts that I looked at, the errors which I am describing are actually serious ones and therefore I have looked to make sure that this is not just something which could be misunderstanding, and it does look… That is why I am quoting Dr Eastgate's own words.

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Q You have said the errors you are describing are serious ones.

A Well, quite clearly.

Q What are you referring to specifically?

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A That they have led to a doctor appearing before the GMC.

Q I am turning to Head of Charge 6, if I may, the referral head. If we can turn to tab 4 of C1, the messages would indicate that there was certainly communication between Dr Eastgate and the social services and the police on 12 July, and Mrs A has given evidence about a meeting she had with Dr Eastgate in the presence of Miss A on 12 July, at which she was told by Dr Eastgate that he had referred the matter. We can look at these messages ---

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A I am sorry, can you remind me where I am looking?

Q Yes, C1, tab 4, page 10. The sequence may not be entirely clear here because there seems to be reference to 11.30 at the top left-hand side. Also written is "Told you 2.40", and then a time of 2.35 at the bottom right-hand side. In any event, it appears there was communication by Dave Evans, who is a social worker, leaving a message for Dr Eastgate on the 12th and the message appears to be:

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> "1. I have informed police.
> 2. Strategy mtg next. 16/7/96.
> 3. Can you supply a venue for meeting",

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and it is timed 2.35. On the preceding page, page 9, the same day, 12 July, a police officer, DCI Sinclair left a message for Dr Eastgate: "Re a little girl", seemingly at 2.30. By 12 July we can see the notes that were taken up until that date. I want to ask you what your evidence is about the appropriateness of referring the matter at that stage – before we look at parental involvement, the appropriateness of referring the matter at that particular stage. Can you outline what your evidence is before we look at the literature on the topic?

A Yes. If there was a suspicion of abuse… I can try and find it, if you like, and bear with me, but the GMC guideline itself, if we are talking about…

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Q Let us take in that order then. We will go to the GMC guidance.
A Shall I outline it then?

Q Certainly.
A My view is that it would be correct and appropriate to take at least basic steps to verify information; to have checked about the safety of the child – and lots of the guidelines refer to children who are in dangerous positions; to have conferred with the people with parental responsibility; certainly to have conferred with other people experienced in the field of child abuse. It is debatable as to whether that should have been another psychiatrist of similar seniority, though some would say that that should be done. But the essential points would be to take basic steps to check that all the indications are that there is good reason to communicate those concerns with the parents under these circumstances before taking other action.

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Q You referred to the GMC guidance. Let us look at the annual report in 1987, which is in the literature bundle, tab 6, page 15. The heading is: "Professional confidence: cases of child abuse." There is a passage towards the bottom of that paragraph:

> "On the recommendation of the Standards Committee the Council in November, 1987 expressed the view that, if a doctor has reason for believing that a child is being physically or sexually abused, not only is it permissible for the doctor to disclose information to a third party but it is a duty of the doctor to do so."

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Then we turn to the guidance issued in October 1995, so shortly before these events, which is paragraph 11 in tab 5:

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> "If you believe a patient to be a victim of neglect or physical or sexual abuse, and unable to give or withhold consent to disclosure, you should usually give information to an appropriate responsible person or statutory agency, in order to prevent further harm to the patient…".

Then, if I can ask you to turn to the Wiltshire guidelines which were operational where Dr Eastgate was working at the material time, they are in tab 7, paragraph 5.1.8.

F

> "General Medical Council (GMC) guidance states that the belief that a child has been the victim of abuse or neglect will usually require a doctor to disclose the information to an appropriate person or authority. A decision to communicate such knowledge, therefore, rests with the doctor who should be prepared to justify his or her professional decision, not only to his or her peers either locally, on the GMC, or ultimately to the Courts. However, on the assumption that such referrals have been based upon sound clinical evaluation and judgement, then the doctor would not be blamed for acting in good faith and in the best interests of the child."

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Can I look please at these circumstances in the context of whether or not the referral was based on sound clinical evaluation and judgement. The notes we have by the 12th

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A comprise the notes on the 9th, which you have already given your evidence about, the file note dated the morning of the 10th and the afternoon of the 10th, and the 11th, all of them on page 8 of tab 2 in C1. What is your evidence about whether a referral on the 12th, in the circumstances pertaining to this case, was based on sound clinical evaluation and judgement?

A I was looking for a different GMC reference and it may be one of the others – if you would like I can try and find it – where, if there is likely to be serious complaint

B against a doctor, the originating doctor should take steps to verify the facts. That is the statement. If you like, I can try and find that. It is here because I have tagged it somewhere.

At this point the child is safe. The nature of the alleged abuse is such that it might cause distaste, and we can have a look at the implications of this. But there was no risk of, there was no escalation within the allegation. One might argue that there was

C an urgency because of the risk to other children, but we are talking about an event at least a year previously.

Q Pausing there, the last appointment with Professor X had been 29 August 1995?

A Yes. We say at least. I am sorry. It is eleven months.

D Q It is eleven months, yes. So, when assessing whether there was any urgency for a referral in these circumstances, what do you say about that?

A It may not be appropriate for me to point this out but yesterday, when we were listening to the evidence from the mother, the Council's reaction was to ask the mother for clarification.

Q Yes. Mr Harrison asked Mrs A a number of questions about the lay-out of the

E room, the location of the examination couch, the existence or otherwise of a screen, and so on. What do you say about that?

A I would have expected the doctor, even if he was quite severely concerned, under these circumstances, with the child quite clearly safe, to have at least carried out the same degree of questions for clarification of the circumstances. It is not verifying the abuse, but it is just trying to clarify what might or might not have happened. I would certainly have expected them not to have seen – and I know there are various

F arguments about influencing the child – but it is my advice that all the guidelines indicate that the parents of a child under these circumstances should be involved and it should be discussed with them at every stage.

Q Can I leave head of charge 6(b) on one side for the moment and just concentrate on the part of the allegation that is related to the referral rather than the absence of the parental involvement. You have said that there should have been

G further questions of the child to verify or clarify what the allegation was?

A I am sorry. I did not quite catch that.

Q You said that there should have been an attempt by Dr Eastgate to clarify the nature of the allegation in order to assess whether it was a reasonable belief that he was coming to. Is that right?

A It is a very complicated question. By this point a number of things have

H already happened. That is, that it is no longer clear as to whether the Committee child

A has spontaneously identified the doctor concerned. An opinion has already been given to the child. Under normal circumstances one would want the youngster to continue and clarify against the background when there had been no leading. I am afraid by this point it cannot be done, and that is one of the problems. I would certainly have expected this to be recorded in great detail.

Q Turning to the file note, tab 2, page 8, there are some notes, short thought they

B are, relating to the 10th. It appears that in the morning session of the 10th there was some conversation between Miss A and Dr Eastgate about what had happened. She has stated on one occasion her grandmother left her, leaving just her and Professor X together. Then, in the afternoon session:

> "She described an occasion when he pulled her bra down, when she was just 10, and again stroked her breasts. On that occasion he also touched her in the
> C lower body, but did not remove her underpants. On another occasion he did. [She] was quite distressed in describing this....".

There was have some details being ascertained. What is it you would have expected Dr Eastgate to have ascertained over and above that sort of material on the 10th?

A It is not even so much the detail. It is the manner of eliciting this information. If the style of interviewing was similar to that that appeared on the morning of the 9th,

D then one would have to say, interpreting this is almost impossible. If there had been detailed verbatim accounts, then one could look at that. The difficulty here is that it is not possible to tell whether this was a spontaneous allegation or not. It is difficult even to tell what her reaction was at that time. It would, for example, have been possible to ask maybe the doctor concerned, but the parent, what was her reaction afterwards. But the difficulty here is that we do not know from these notes how spontaneous, how much detail was given, and whether anything was said even during

E these. I am afraid that is the position, that the lack of notes and the style of interviewing actually leave both for the GMC here but also for what to do after that.

Q Was there, in your view, on the information that you have before you, by 12 July any other potential explanation other than abuse of what could have happened?

A Post hoc explanations are difficult, but my understanding is that in the absence

F of any civil finding of abuse, any conviction in the criminal courts for abuse, and a denial by the child and an agreement that it did not take place, I think one has to point out that therefore by definition a wrong conclusion had been reached. Therefore there would have been another explanation.

Q That is with the benefit of hindsight, of course, is it not, Professor Zeitlin?

A But nonetheless I am pointing out that there would have been good reason to

G have looked for other explanations. This is a child, again, who was irritable, who was aggressive, who was resentful of a variety of people; who had been by then in the unit for.... I wonder if you can remind me how long she had been on the unit?

Q Since 13 June

A This is now three weeks later, I think. Is that correct?

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A

Q In assessing the situation on the 12 July, what other potential explanations do you say might or should have occurred to Dr Eastgate?

A Again, it depends on the spontaneity of her response and her statements. But could, for example, this angry, unhappy girl have listened to what other people had said about abuse?

Q We know that Professor X was engaged in something called "Tanner Staging".

B

Yes?

A Yes.

Q Which involves an assessment of the development of puberty, by looking at the breasts and the public hair. Does that have any relevance to any consideration that should have been undertaken at the time?

A This is where I say looking for clarity. In my original report I say it might be

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debatable as to whether there should have been a check on the circumstances with that doctor himself to clarify the circumstances. We heard in evidence this morning that stroking and touching on the genitals would not be part of it, but could this be a misinterpretation by the child, reinforced then by a comment that, "That sounds wrong". So, if one looks at some of the statistics on the validity of allegations, originally it was said that only five per cent are deliberate lying. But when one looks more carefully it becomes apparent that only about 70 per cent of clear allegations are

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valid, or at least what appear to be clear allegations. The reason is that about 25 per cent are misinterpretations. If a child is being examined where it would be expected that the state of the breasts and the state of public hair would need to be examined, then consideration of a misinterpretation should at least have been in the mind of the doctor. Bear in mind, as I say, about 25 per cent or so are in fact misinterpretations.

Q There have been various definitions of sexual abuse provided over the years.

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The allegation made at this stage by 12 July against Professor X, what do you say about the allegation itself in the context of allegations of sexual abuse?

A In any circumstance in which there might be a question of abuse, it is reasonable for a responsible doctor to consider the possibility. However, if we are looking at the issues about, "... if there is a suspicion...", firstly, what is the risk to the child? In these circumstances, the child is in a protected environment. The nature of the abuse: there is a literature on the likely dangerousness in terms of future

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psychological health. The parameters are the painfulness, the instrusiveness and penetrativeness of the abuse, the persistence and constancy of the abuse and the relationship with the abuser. Now that does not really apply here. There is research actually – I think it is on university students – looking at recall. One might compare this with touching or stroking or a pinched bottom. They are remembered with distaste, but there is no real evidence that they have the profound effect that can occur from persistent intrusive abuse. Now, the significance of that is, was it urgent? There

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was no suggestion of escalation, that is that the doctor was involved with a different case where the doctor concerned had made a special arrangement for the child to come back and had said, "It's okay. We don't need anybody with you." These did not apply here. There is no evidence of escalation; there was no evidence that Dr Eastgate reasonably asked, "Were there any photographs". No, there were not. So that the grounds for urgency in terms of damage were not present in my opinion.

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Q You have made reference to asking for any photographs which may be relevant to urgency – that is page 9, the file notes there, 15 July. Another feature of the case at this stage was that apparently, according to the material gathered by Dr Eastgate, there was, in fact, somebody else present on each occasion although the child was saying that her grandmother had left on one occasion, but her mother was there. That brings us on to the other part in head of charge 6, the failure to consult with the parents before making referral. What do you say about that?

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A All the directions that I have seen, and all the guidance notes, are that there should be involvement of the parents at every stage even if it is suspected that they could be involved in abuse.

Q Can we look, please, at some examples of that guidance which, as you say, is found throughout the literature bundle. First of all, *Working Together*. Tab 4, paragraph 1.4.

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A Is this under "Introduction"?

Q Yes, under the heading "Introduction". Paragraph 1.4, the second sentence, four lines down:

> "As parental responsibility for children is retained notwithstanding any court orders short of adoption, local authorities must work in partnership with parents, seeking court orders when compulsory action is indicated ...."

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and so on. Paragraph 5.4, which is at page 25.

> "The essential principles of the Children Act provide the foundation for work on individual cases. They include:
>
> - the focus on the welfare of the child taking account of the child's views in the light of age and his or her understanding;
> - partnership with parents and other family members, and support of the child within the family whenever possible;
> - the concept of parental responsibility."

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Then 5.8, over the page, page 26:

> "The importance of family involvement in child protection work has been increasingly realised ...".

And paragraph 5.12.2 at page 28. I refer you to the last part of that paragraph, six lines up from the bottom, which reads:

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> "The urgency of the situation should not detract from every effort being made to ensure that those with parental responsibility are given appropriate opportunity to participate throughout the process, and efforts should be made to facilitate appropriate contact between the family and the child(ren) through the course of the emergency protection order."

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The Wiltshire guidelines, tab 7, paragraph 5.2.11:

> "Ensure that there is as much openness and honesty as possible between the family and the professionals, recognising that the interest of the child is the priority."

That is Wiltshire guidelines, tab 7. You should have 5.1, which is headed "Primary Healthcare Teams," and then some diagrams, and then section 5.2, which is headed "Nursing and Paramedical Staff". Then, over the page, 5.2.11.

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THE LEGAL ASSESSOR: No, we do not have it.

MISS GLYNN: I see. I am sorry about that. It reads:

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> "Ensure that there is as much openness and honesty as possible between the family and the professionals ...".

MR TURNER: We do have the whole of that for the Committee.

MISS GLYNN: Can we turn to Kolvin, which is tab 2, page 57 at paragraph 6:

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> "• The parents should be given the same courtesy as the family of any other referred child. It is important for professionals to allow parents to talk about their problems and concerns freely, and within a helping or enabling context, and without a display of emotive overtones by the professionals. Furthermore, the existence of bias or prejudgement on the part of the professionals may act as a considerable barrier to such a constructive context being developed in any particular case."

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Page 57 – you will find the pagination at the bottom right hand side. Paragraph 8 is headed "Talking to Parents or Caretakers":

> "The findings should be communicated to the parents, the differential diagnosis discussed, and the need for further investigation explained. It is good practice to give parents detailed feedback. An accusatory stance by the physician is inappropriate."

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Still with Kolvin if I may, paragraph 12, which is page 59. You will see the second italicised section there:

> "*Feedback to parents and other adults*. The paediatrician or child psychiatrist should discuss and explain findings, differential diagnosis and conclusions without being accusatory. It can be useful to invite adults to see matters from the child's perspective when reviewing the situation with adults involved in the case."

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Whilst we have that page open could I refer to the italicised bullet point at the bottom of that page on the left hand side headed "Open-mindedness":

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> "This is important, as abuse may or may not have occurred; there may be fabrication or we simply may not know or never know. It is for this reason that we have to depend on the balance of probabilities which, in turn, is dependent on physical, family, social and psychological evidence. For these reasons, family assessment is essential. Where there are doubts or disputes, it is helpful to ascertain whether information at interview tallies with information from other sources."

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A Perhaps on that page we could look at paragraph 14 as well.

Q Yes, which particular passage would you wish to refer to?
A "Sexual abuse does not usually call for an *emergency medical response ..."*

Q Yes, the bottom right hand side:

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> "Sexual abuse does not usually call for an *emergency medical response* unless: there are serious health risk to the child ... or there is serious psychiatric disturbance."

That, of course, is referring to an emergency medical response rather than a referral to the Child Protection Agencies?

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A Yes. I am still pointing out the emergency nature.

Q Then if we can turn to tab 3, which is *Diagnosis of Child Sexual Abuse: Guidance for Doctors*, page 6, paragraph 6, "Talking to Parents":

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> "Involving parents in discussion should follow the usual principles of good clinical practice. In a case of suspected child sexual abuse they should be given every opportunity to communicate their worries and concerns in a non-emotive atmosphere. A differential diagnosis should be fully discussed, and even in those cases where the parents are suspected of being the perpetrators of the abuse, the doctor should not adopt an accusatory stance. If further investigation is required, the reasons should be fully explained and the parents informed of the results. It is important to maintain positive relationships with the parents as far as possible throughout the whole process of the enquiry."

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If we turn over to page 8, paragraph 8.2, "Information or allegations from others":

> "These may be parents, relatives, neighbours [and so on] ... Informal discussion will be needed with a colleague or colleagues experienced in the subject, and this can often be conducted by telephone."

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The guidance that we have looked at from three other sources, Wiltshire and two GMC sources, refer to a "belief". You have referred to "suspicion" on a number of occasions, Professor Zeitlin. Can we be clear what needs to be established before a referral is made?
A As you know from my various reports, I have discussed this in a variety of ways. The whole issue about a belief that abuse has occurred was a big issue from the late 70s up to Cleveland. That is why Cleveland was a watershed, in that it was previously assumed that if there was reason to suspect if then it probably has occurred

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– no smoke without a fire. I could show, if you like, mathematically – quite seriously I have a mathematical model which will show you why that produces the confusing problems that arose in all these locations, why neither the people who were identifying abuse were wrong, nor the people who said that lots of children were incorrectly identified as being abused were wrong. If you start with a belief that there is no smoke without fire then you get into that sort of chaos. You can look at the term "belief" in a different sort of way, and that is at what point do you think that it is more probable than other explanations. Looking at what might be reasonable to clarify the facts and the information is at least one step. You can say that an allegation has a 70 per cent probability of being valid and therefore it is more probable than not that the allegation was valid. Under these circumstances it is not a clear allegation. It might have been if there had been detailed records – we might have seen a clear allegation, but they are not present. Under those circumstances with this angry, resentful girl, a girl who was angry at the doctor named, who was having an examination which would involve examination of breasts and genitals anyway, to seek to verify the facts would have been at least a preliminary step to raising the probability to a sufficient level to proceed further. Bearing in mind that, as far as I can see from the notes, Dr Eastgate was already aware that it could become a GMC issue – in the notes he puts "GMC ?" – in terms of belief it had happened, taking steps to increase the probability, looking for some corroboration of the facts or the circumstances, would have been consistent with increasing – that is why I say "belief" is a difficult word to use here.

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Q When you refer to the reference to the GMC, this is because the allegations were being made against a medical practitioner?
A I refer to that because he was aware of the seriousness and aware of the consequences and aware of where that might go to.

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Q Looking at the seriousness and the consequences and the background to this allegation, the child herself with her characteristics, her apparent dislike of the medical practitioner and the allegations themselves, in your professional opinion was this referral on 12 July based on sound clinical evaluation and judgment?
A I would go back to the GMC's own statement that the practitioner should endeavour to clarify and find the facts before taking any other further action.

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Q I am sorry to press you on this, Professor Zeitlin, but I think the Committee needs to understand what you are saying about this. Given those matters I have just promulgated, was this referral on 12 July based, in your professional view, on sound clinical evaluation and judgment?
A In the absence of detailed notes, the presence of leading questions – what appear to be leading questions – in the transmission of an opinion about what the child appears to describe, to the child, the child under the particular circumstances which we have described, I have to advise that it was not sound clinical judgment and was contrary to guidelines that were extant at that time.

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Q Can I move, please, to the consequences, potential consequences, of such a referral in these circumstances, looking first, if we may, at *Kolvin*, which is tab 2 of the literature bundle, page 57, top left hand side:

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> "The presumption that abuse has taken place before the evidence is available has particularly damaging repercussions for the child and family."

May I ask you to turn to *Working Together*, tab 4, paragraph 5.11.3, page 27, which reads:

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> "The balance needs to be struck between taking action designed to protect the child from abuse whilst at the same time protecting him or her and the family from the harm caused by unnecessary intervention."

So there is a reference there to the balance on the one side to protecting the child, which you have already given evidence about. You have described how the last appointment was almost a year before and there was no immediate risk to the child; and on the other side the harm caused by unnecessary intervention. What do you say about this case when applying that balance?

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A In terms of whether there was a need to act on an emergency basis to refer the child urgently to Child Protection, I cannot see that there was any direct benefit to the child without any further attempt to clarify the circumstances and most importantly without a discussion with the parents. Where there are issues about whether the child would have wanted discussions with the parents or not, the guidelines indicate that the family should be kept informed and the matter should be discussed with them at all times.

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Q Could it be justified on the basis of protecting other children from Professor X?

A To be honest, I think that is something that the GMC would have to evaluate for themselves bearing in mind the nature of the allegation and the long duration of interval between the alleged event and the point of allegation. I would have to say it would be for the GMC to consider whether that was an indication for urgency without any clarification.

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Q What do you say about it?

A It is my view that in the uncertain, no, it is not an indication. Obviously Dr Eastgate, himself – he raises the issue, not the child, for obvious reasons – about protecting other children, but it is my opinion that it was not a reason for the urgency of the action.

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Q Going back to the balance between the requirement to protect the child or perhaps even other children and the potential harm done to the child and the family where there is an unnecessary referral could I ask you to turn to *Working Together*, paragraph 5.14.10, page 30. There is a reference there four lines into the paragraph that reads:

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> "The process of investigation is painful and difficult for those who undergo it. The fact that the allegation is unsubstantiated may not of itself be a relief. Letters following unsubstantiated allegations should acknowledge this and the distress which has been caused."

Does that accord with your experience in your professional life to date?

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A Yes.

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MISS GLYNN: Yes, thank you very much, Professor Zeitlin, you may be asked some further questions.

THE CHAIRMAN: Professor Zeitlin has been giving evidence for a long time and I wonder whether we should take a break now and start again at 1.45.

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MR TURNER: Certainly, sir.

THE CHAIRMAN: Professor Zeitlin, you are under oath, as you know, you may not discuss the case with anyone.

(Luncheon adjournment)

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