

GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Friday 5 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 FIVE – 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: Good morning. Mr Turner?

MR TURNER: Sir, I call Dr Alison Hall.

ALYSON HALL, Sworn

B THE CHAIRMAN: Dr Hall, the Committee are grateful to you for coming to help them determine the facts in this case. I should say that they have all read your report with care overnight. I think you are familiar with the arrangements in the room and how the hearing goes, so I shall say no more.

Examined by MR TURNER

C Q Dr Hall, can you tell us your full name, please, and your professional address?

A Dr Alyson Hall; the Emanuel Miller Centre for Families and Children, Gill Street, London E14 8HQ”.

Q And your occupation?

A I am a consultant child and adolescent psychiatrist.

D Q I think you have brought along, for the assistance of the Committee, your detailed CV?

A Yes.

MR TURNER: Unfortunately, sir, I have not yet been able to get copies of the CV made. My instructing solicitor seems to have been held up. Copies will be obtained as soon as possible.

E THE CHAIRMAN: Thank you.

MR TURNER: Can you tell us the bare bones of your CV? What are your professional qualifications, please?

A I am Bachelor of Medicine and Surgery; I am Member of the Royal College of Psychiatrists, Fellow of the Royal College of Psychiatrists and Fellow of the Royal College of Paediatrics and Child Health.

F Q What professional appointments do you hold at the moment?

A My main appointment, which I have held since 1982, is consultant child and adolescent psychiatrist, which was originally at the Royal London Hospital; it is now held with the East London and City Mental Health Trust. I am also honorary senior lecturer in the department of psychiatry of the St Bartholomew’s and Royal London School of Medicine and associate dean in the medical school for undergraduate education.

G Q Can you tell us a little about your background training and professional experience, please?

A Having worked in the London Borough of Tower Hamlets for over 20 years now, obviously, because it is such a deprived borough, from the outset as a consultant there I have achieved extensive experience in the area of child abuse and child protection, fostering and adoption. Indeed, when I was appointed, it was agreed that

A I would take a special interest in that area because it was needed within the department that I was working in. I have been on the area child protection committee for most of the time that I have been in Tower Hamlets. When I first became involved, child sexual abuse was not even mentioned in the Area Child Protection Committee guidelines back in the early 1980s. Obviously, I have been very much involved in helping, with other colleagues of other disciplines, people to manage child sexual abuse, which is an area which was of particular focus in the early 1980s prior to Cleveland, helping people to manage this difficult area. More recently I have been involved particularly in the issue of neglect, which is another area of child protection which has not been very easily managed by our colleagues in both health and social services, and I have done research in that area more recently. I am the named doctor for child protection for our trust for the Tower Hamlets locality.

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C Q As time has gone on, over the past 10 or 20 years, have there been changes in the approaches adopted to the investigation and treatment of child sexual abuse?

A Very much so. As I mentioned, in the early 1980s, although child sexual abuse came up in clinical practice for psychiatrists as an event that had happened to children, often for example reported by older patients, people were very inexperienced in dealing particularly with very young children when sexual abuse came to light. In Tower Hamlets, recognising the difficulties of managing the cases, we set up a multi-agency advisory group which met regularly so that professionals who were concerned about these cases could come to get advice, and in a sense it formed – it was well before *Working Together* – the bones of a strategy group really to provide experienced advice on how to manage cases. We had senior police involved.

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E This was prior to Cleveland. In those days – and we are talking about 1986 – child psychiatrists and paediatricians were actually involved in the diagnostic work quite often and obviously after Cleveland the *Memorandum of Good Practice* was developed and the Metropolitan Police set up joint investigations with social services and we were, thankfully, relieved of having to have a role except in the most complex cases, for example autistic children. I remember one case I had to see because it was a deaf child, a child with very serious learning difficulties. On the whole, we have stopped being involved in the investigative work and in fact, although one of my other responsibilities is that I am the joint programme director for the training of specialist registrars at the Royal London and Great Ormond Street, one of my concerns nowadays is that specialist registrars do not have experience in assessing sexual abuse, so that they are going to be in more difficulty than, for example, we in the era of child psychiatrists who have had that experience and who would be able to handle more easily a situation as in this case where allegations come up in therapeutic work.

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G Q Paraphrasing, you said, “Thank goodness, clinicians do not generally have to get involved in the investigative process”. You mentioned the *Memorandum of Good Practice*. Who is that *Memorandum of Good Practice* primarily directed towards?

A This was really to assist in the interviewing of children and really to set up specialist teams to do this work. It is obviously aimed at all professionals who are involved in these assessments but on the whole it has been police and social services who have undertaken the main body of that work. But it would guide all of our practice. If somebody asks you to assess whether a child has been sexually abused or

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A not, then you would follow the guidelines in that in terms of the approach which has been extensively discussed already about not using leading questions.

Q Are the guidelines in the *Memorandum of Good Practice* prescriptive in the sense that they say “You must do this” or “You must not do that”?

B A Not really; they are guidelines. Obviously, as has already been discussed in the hearing, great difficulties are presented if there is very strong reason to believe that a child has been sexually abused – for example there are physical findings or a venereal disease, or something like, or a pregnancy, let us say, and a child has not been able to talk. One’s approach then of how much one would want to --- If you felt the child was in great danger in the living situation that they were in, one might have to be more facilitative than in other cases. But in fact in my experience recently we have tended to --- There is one very difficult child, for example, that I have been involved with in the last couple of years where, from her very gross behaviour, it has been clear that she has been sexually abused but she has not been able to tell anybody about the abuse. One of the approaches was to see if, through therapeutic work, she might be able to talk about what had happened to her. I think that that puts practitioners in great difficulty and very often has no more success in terms of elucidating what has happened to the child. There is some research evidence that when children are not in contact with their abusers, and there may need to be some time for that, they sometimes then can reveal what has happened. But that does not apply in this case because we are talking about a child where the allegations came from outside the family. As I say, therapeutic work with children who have been sexually abused is a very difficult area, whether it is children who have been sexually abused and that is known at the time that somebody takes on therapeutic work or when allegations of sexual abuse, or suggestions of sexual abuse, arise in therapeutic work.

E Q Are there any distinctions that are of significance to the present case, in your view, between therapeutic work and investigative work? Obviously therapeutic work, as we have heard, involves a certain degree of investigation because one of the things you are trying to do is to get to the bottom of the child’s problems, so you are investigating to that extent.

F A I do not like the term “investigation” for therapeutic work; I prefer “exploration”. You are really trying to help – whether it is a child or an adult – the child to understand their feelings, to recognise their feelings, to understand the causes of their feelings and to be able to handle their feelings. Hopefully, in talking and understanding, for the person to understand better their own emotions and how those are linked to their relationships, usually, or events, that person will improve in terms of their emotional state.

G Q Is their, in your experience, or your own practice, any difference in approach when having a session with a child where there is a suspicion or any hint of child sexual abuse, depending on whether you are engaged in a therapeutic exercise or an investigative exercise in a true sense of *Memorandum of Good Practice* type interviews to try to obtain evidence for court proceedings?

H A I was thinking in terms of child psychiatric practice, which is what we are undergoing here. As I have said earlier, child psychiatrists are rarely asked specifically to do investigative work in relation to child sexual abuse. The only times we would do that would be usually where somebody else has done the work first

A because it would be other agencies. The only time that one would do that would be with a very difficult case where our psychiatric skills are needed. In terms of pure investigation, that is unusual. A number of child psychiatrists, who are obviously experienced, like myself, in providing expert evidence for the courts, might be asked to see children in relation to care proceedings and then again the approach would be different from the therapeutic approach. We are doing an assessment – that is what we would call it – rather than investigation. We would be looking at what was in the child’s best interests. In the course of that, we would be very alert, and would not want to put ideas into a child’s mind about what had happened, for example in their family of origin. We would hope to be able to be quite neutral and allow the child spontaneously to say some things about what had happened – it might be that a parent hit them or any other experiences – but we would also have to assist us usually a lot of volume of papers from social services and other professionals describing what has happened to the child.

C My own approach in expert work, for what it is worth, is to do my clinical interviews first and then to read the papers so that I am coming at it in an impartial way and I am not coloured by what professionals or social workers have said. Obviously, you know that if a child is in the care system then something has happened to the child, but on the whole one really wants to hear afresh from everybody involved, including parents in these cases, in an unbiased way, as much as one can, from those. Obviously, it is not always very easy. You might have a foster mother who would tell you that the child told them this, and obviously you would take that and want to hear from the foster mother very carefully the words that the child used. So that is another area of work.

E Then there is the work that happens in therapeutic work, and I would put that on a completely separate side, which I think is obviously the importance in this case, that where, as a psychiatrist, you are asked to see a child, where you might have to have in the back of your mind “Could this child be abused?”, and I think that that is very common in the work of consultants working in adolescent units, when you have inexplicable, very disturbed behaviour, eating disorders, self harm, alienation sometimes from families, where you have to think about “Has there been abuse?”. That is not necessarily sexual abuse; it could be physical abuse or emotional abuse. One has to have in mind what has happened in that child’s relationships with the family in therapeutic work. If you are doing therapeutic work, not just managing a unit and somebody else doing the therapeutic work, you would have to have in mind your relationship with the child, as would all the other staff in the unit, and you would have to protect that. When a child makes an allegation in the context of clinical work, it can be very difficult for the practitioner because they then have to move into a different way of managing the case compared with if the case was proceeding in a straightforward way where you did not have to involve any other agencies.

G I think that the work with adolescents is particularly difficult because you have to consider the age of the patient and their ability to consent. There is a grey area. For example, a psychotherapist doing psychotherapy with a younger child would not be telling the parent the detailed content of the sessions, or anybody else, for that matter, apart from a co-therapist who might be working for the parent. You would be talking in general terms. With an adolescent, it is particularly important that the adolescent

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A feels safe and can confide in the practitioner and to know when they are going to be talking to other people.

B In an inpatient unit it is different again from working in an outpatient setting. In an inpatient unit there is a culture where patients have to expect that the staff will talk to each other. An inpatient unit can work in that way. When it goes to children who have difficulty beginning to confide – it might be nothing to do with the family, for example a child who is deeply ashamed of some experience at school, let us say – they would not want, necessarily, to think that the therapist was confiding inappropriately. In terms of trust, I think it is very important that a practitioner is open about who they are talking to. So there is a difference in therapeutic work.

C There is also a difference in terms of record-keeping. Most therapists, whether they are psychiatrists or psychotherapists, if they are doing therapeutic work, will keep personal records to assist them in that therapeutic work – things to remind them or sometimes to take to supervision for discussion.

D Then there is the issue of writing and keeping people informed. My impression has been, generally over the years, supervising staff, that people engaged in therapeutic work get very involved with the young person and often are bad at communicating with other people in the system, such as the GP and parents, and so they might write a lot down to help them in their therapy and for supervision but may not write good letters to keep people updated about how the therapy is progressing. Partly, it is very difficult to move between the two about how you communicate. I think that that is important in relation to the difference between therapeutic work and investigative work or assessments for the courts. When I do an assessment interview for the courts, I will sit there scribbling as fast as I can everything that is told me, but that is on the understanding that everybody involved in the process knows already that that is why I am doing it. Sometimes people – parents or children – are anxious about what I am writing down, and again I have to remind them why I have to write it down and that it will be read by everybody involved in the court case, and that is quite different.

F The most difficult cases I have encountered in clinical practice, having had so much experience in this area, are where you have a therapeutic role, where you have an alliance with the child, and suddenly then you are asked to provide written information for other purposes and so you are having to break with the rules of engagement that you had with that patient and risk jeopardising the trust, so handling that is very difficult.

G Q Professor Zeitlin, whose evidence I think you were present for and heard, seemed to be suggesting, the Committee may think, that if in the course of a therapeutic session disclosures suggesting sexual abuse are made, any competent clinician should be able to switch immediately and easily to the role of full, detailed recording of the sort that a court would need for legal proceedings. Do you accept that?

H A I think it is very difficult. I do not think it is as easy as he makes out. Obviously, Professor Zeitlin and I are very experienced practitioners. I find it difficult; I know many of my colleagues find it very difficult. I think an inexperienced practitioner would find it exceptionally difficult. I think the difficulty lies with trying to balance, maintaining an engagement with the patient, holding doubt

A in your mind at the same time, especially when it comes, as in this case, to an extremely surprising allegation but a very serious one, if what the girl said proved to be the case. I think the practitioner would inevitably have a great deal of anxiety and have to contain that anxiety to concentrate on the patient, concentrate on taking what she says seriously and thinking at the same time, "What have I got to do about this?" I think it is very different than when you have been focusing on the patient, thinking about the patient and trying to understand them and listening to all the little clues that they give you, which help you to do sensitive work. Suddenly, at that point, when the child says something that is worrying and would inevitably be difficult to handle, the practitioner's level of anxiety is bound to increase, I would say. I think it would be very strange if it did not. So containing that and focusing on the patient is a very difficult task. With the benefit of hindsight, you could look at all different ways a case like this could be handled, with slight subtle differences in timing and what was said. Unfortunately, as we have all said, we do not have a full account of Dr Eastgate's records to know exactly how he handled it. It is a very difficult and sensitive clinical task.

Q Does it surprise you that we do not have detailed records of precisely what went on in those sessions between 9 July and 19 July?

A I think that ideally one would have had more detailed records, but it does not surprise me. I read – and I had not known John Eastgate before I first read the papers in relation to this case, so I came to it looking at what an average child psychiatrist would do under these circumstances – and I took it that he was an average child psychiatrist, and we tend to be very busy people. I had not appreciated at that time what his responsibilities were, and I only heard that yesterday in relation to his workload. I thought that actually the quality, particularly of the account of the first interview, which I think is the crucial one, the morning of 9 July, which actually describes in fairly good detail how the girl came to start to focus on Professor X and her concerns about him, was well described. But, after that, given that I think once you get into the mode of having to do something about an allegation, you are thrown off-course, and you have to think, as he did: he had to talk to members of staff in the unit; he had also then, as he did, to speak to social services; there was the plan to get the strategy meeting under way; he had to give a detailed account to social services. He was going on holiday shortly afterwards. He had all his other cases. I know what it is like and everybody knows in most professions what it is like just before you go on holiday. I think it would be easy if he was focusing on making sure that the right things were done as he did, and one could criticise him, and ideally he would have written a much more detailed account, particularly of the afternoon of 9 July, so that we could all judge here whether or not it was a spontaneous allegation, because I think that is the key here. It is a question of judging that. But I think in terms of courts and records, he is not responsible for the investigation. His responsibility was to alert others that there is a concern here that might require investigation. Different details of that investigation would have had to have been carried out by the police, so he was not responsible for every detail. His job was to obtain sufficient information from the girl to feel that discussion with social services was warranted, as the first step, and then by the strategy meeting, as he did have a bit more information because he asked about the layout of the room, et cetera, to help to assist the strategy meeting in making a decision about whether the investigation should go further. We can all look at this case with the benefit of hindsight, but if we look at it in isolation about the allegations of Professor X and what any child psychiatrist would have done, I think a psychiatrist

A in that position has three choices. One is to ignore the allegation and reassure themselves once the parents were present. Obviously, this is a professional person. He would have had to have examined it in a staging examination: there is nothing wrong here; this is just the girls' anxiety about her body and being at a sensitive age and we can ignore it; or he could have kept an open mind and not done anything but waited and seen, maybe getting some advice; or he could have made the referral, as he did, because of the risk and concern about possible risk to other children. I think it is a standard of high professional practice to have the courage to do the latter. I think Cleveland, because it achieved such a high profile, and I think the court system, particularly in relation to allegations of sexual abuse in divorce cases, have given the investigation of sexual abuse a bad name, in a way. It is a very, very difficult area and I think no child psychiatrist wants to find sexual abuse; it makes our lives much more difficult. It is a very challenging area to deal with. It is very time-consuming and we do not look for it. So I think the easiest thing would be to reassure yourself: oh, there is nothing serious here, and not to have the courage to do something about it. I think the highest and most ethical person has the courage and did exactly properly what should happen, which was to seek advice of other people.

Q If you do something about it, if you consult with someone who is the coordinator first of all of the child protection team and you are a consultant child psychiatrist, your expectation is inevitably going to be that, if you are concerned about it, that person is going to say, "If you are concerned about it, doctor, let's have a strategy meeting"?

A Not always, no. Sometimes we would want to look for reassurance and for it not to go further. So I think there is a pull towards, "well, let's not take it further", I suppose, in terms that you would not necessarily expect that they would take it seriously. I do not mean "take it seriously" but feel it was worrying. Sometimes it may be very difficult to prove anyway. I think you would want at least some checks to know whether there were any other allegations made against that person, for example, but maybe that would be all that could take place. In this situation, problems of investigating something like this, where you have got a very disturbed adolescent who was much younger at the time that allegations were made, in terms of actually doing any more than checking whether there were other allegations would be very difficult, apart from taking statements from her and from her mother and grandmother.

Q Do you think there are advantages or disadvantages in involvement of an interdisciplinary strategy consideration at an early stage?

A I think Harry Zeitlin was referring the other day to concerns about: if you blow the whistle in terms of letting other agencies know that there is a problem, you might set in course an over-zealous investigation that might be to the detriment of the patients. That is what I understood him to be saying. I have to say in the early Eighties that was a worry. I certainly was in the situation where I can remember one case particularly where a girl had been assaulted but she did not want to be involved in an investigation. At that stage, I took the precaution, when I sought advice which it was appropriate for me to do, to do it on the understanding – and the girl understood it – that she would not be named and I would not reveal her name. A gain, it was another issue where she had been attacked and there might be somebody out there who could attack other young people, and so I wanted the police to have as much

A information as I could get, so that that would help them and to get advice about whether that was the right thing to do. I think it also depends on your relationships with your local child protection colleagues, the experience of them. For example, you could be in a situation as a child psychiatrist, let us say, in one part of the country and the person who is the named doctor was very inexperienced; let us say they have just taken on that role but really had not had much experience. Particularly with sexual abuse, as I was saying, I think the younger generation of child psychiatrists have much less experience than us older ones. You might not want to go to that person if you felt they knew less about the management of these cases than you yourself did. You might choose to go to a senior social services person who had got a lot of experience. I think there is a choice any practitioner has who they seek advice from. They might go to somebody within their own team, a senior colleague within their own team, for advice, or they might seek a colleague who has all the expertise who they know of in another part of the country to get advice without naming the patient.

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C I think people have to choose selectively who they would go to. But if you have trusting relationships with your local child protection colleagues, which certainly it seems that Dr Eastgate has, and I have myself, having been very fortunate in having worked so closely with social services and other agencies in Tower Hamlets for so long, I would have no doubts about who I would turn to for advice in a difficult case, and I probably would go, because I am probably the most experienced in my own patch, to social services for advice rather than to another colleague. I might turn to somebody else elsewhere, if it was a really difficult case, for advice if I felt that I needed the kind of expertise that was not available locally.

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Q So you say it depends on the particular circumstances, the particular individuals involved and the relationship with the local social services and child protection team?

A Yes. I think, though, the other thing is that when we talked about unleashing an inappropriate investigation, that that could be a decision made at this strategy meeting, that a doctor whose patient it is, say compared with anybody else who brings allegations, is in a very powerful position because it is her duty to protect her patient. I think that if they were to say at the strategy meeting, "Well, what you are proposing I think would not be in the interests of the patient", then the other professionals would respect that.

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Q We have heard yesterday afternoon in evidence, and I do not know if you have read a transcript of Mr Evans's evidence ---

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A No, I have not.

Q What he said was that certainly in the child protection team in Wiltshire the priority is the best interest of the child, even if that is at the expense of a full investigation.

A Yes.

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Q Does that accord with your personal experience of child protection teams?

A Yes, and of the police, I have to say. I am talking about nowadays, but even in those days we had a very, very thoughtful senior police officer, and have done since. There is this tension between catching a criminal and having to accept that you are not going to be able to have sufficient evidence, or it may not be in the interests of the child, as it would not have been in this girl's case, to have made statements. Police

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A officers are very sensible about that. They have come to accept how difficult it is when there is a very clear-cut case of sexual abuse, to secure a conviction. I had the police only in the last couple of weeks wanting me to make a statement for a judge in relationship to a teenager who had been raped. He said to me, "This girl is in a terrible state. You must do what is in her interests". They had DNA evidence but it meant letting a rapist go free.

B Q You said "raped" not "allegedly raped". No one has been convicted of raping her.

A No, that is right.

Q You said that there was a problem in the old days in the early Eighties sometimes about referring matters to other agencies.

A Yes.

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Q Was that before Cleveland?

A Yes.

Q Has the philosophy generally over the country changed at all since Cleveland?

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A I think so, and I suppose I am more concerned about the fact that sexual abuse nowadays – and I am involved as an expert witness for the courts, mostly for Tower Hamlets but I have done quite a lot of work for the Official Solicitor as it then was and for other local authorities – as the primary reason for a child going into care is now rare. It is largely children where there are other concerns about parenting, and sexual abuse comes up as one of the issues. Again, as one of the difficulties in the court system of handling and proving sexual abuse, on the whole, and it being difficult for judges to make a finding of sexual abuse, it does not feature as the main reason for care proceedings and findings are not often made. Often it would be on

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other grounds, in terms of neglect of physical abuse, that the care proceedings proceed or go on. The climate has completely changed. The other area that has been very salutary really is that we are not talking about a case like this where there was a spontaneous allegation as I understand it of what sounded like physical abuse, that there is strong evidence that unless an allegation has been made, interviewing children, investigative interviewing, is rarely helpful. Very few children, unless they have made a spontaneous allegation, will rarely say what has happened in

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investigative interviewing in the type of the memorandum interview. I think there is a dilemma because prior to Cleveland in psychiatric work we were as facilitative as possible. I think therapeutic work has to be very sensitive, picking up clues that patients have said and bringing them back to the patient, noticing the patient's emotions at certain statements and where people are mentioned. So we are leading the patient without any preconceived notion in their mind to help them to talk about what distresses them and what concerns them. Once there is an issue of sexual abuse, I think that is illustrative of the difficulty of this work, because you have to change and use a different approach if there is a question that there could be court proceedings or child protection proceedings in relation to an allegation.

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Q You mentioned earlier on the benefit of hindsight. You have told us that you have had hands-on clinical experience and that you also have experience of working in the context of court proceedings. Usually care proceedings or criminal proceedings, would that be?

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A A Rarely; I have never actually had to give evidence in the criminal court. Every time it has come to it, like in relation to this last case that I have just mentioned, I have never had to give evidence in court.

Q You have been involved in preparing evidence for criminal cases but never actually had to stand in the witness box?

A Yes.

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Q But in care cases, you have both made reports, investigated and given evidence before the courts?

A Yes. I have actually read transcripts of criminal proceedings because sometimes care proceedings come up after criminal proceedings have happened, and also I have read and seen how different the two systems are.

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Q If you look back, with the benefit of hindsight, at the detail of the way in which you have conducted any given case that you have been involved in, do you think you could pick out in an analytical way factors for which you might be criticised?

A Absolutely, and I think any child psychiatrist would. I think the problem is that child sexual abuse arouses strong emotions. Of all cases, it is odd really, because if you think of physical abuse, most parents have smacked their children, but when it comes to severe physical abuse, most parents have not. People are not emotive about it. They can understand how some parents could lose control. Although it is unforgivable and there could be serious injuries, people do not get so emotive about it; nor with neglect. People feel rather paralysed by neglect. Emotional abuse is a much more difficult concept inevitably because it is about relationships and very abnormal relationships. But sexual abuse, people are either horrified by it or fascinated, but people find it very, very hard to judge and believe that these kinds of acts can take place. So I think all of our judgments are affected by that. It is very hard to – you see a child and it arouses a lot of emotion, to think that such an awful thing could have happened to child. So it is much easier to think, “Of course it did not happen”, because emotionally it is so hard to accept. It is very, very hard to interview a person, usually a man, as part of one’s assessment and to think, “Could this man have actually done that to this child?” I think it is even more difficult – I have found in my experience in the court system – with the middle class families than with very deprived families who are really managing their children very much on the edge.

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I think people find it much more difficult to think about these cases clearly and objectively when they can identify more closely with what it would be like to be a father who is wrongly accused or a mother who is in a terrible dilemma about whether she should choose between her husband or the child. I am talking about intrafamilial abuse there. It is a very, very emotive and difficult area.

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Q Is an allegation that a doctor has abused a child something that you would dismiss out of hand if you heard it from a child?

A I think my first inclination would be to think, “Is this child reacting to embarrassment because of the age that she was when she was examined?” It is very powerful. Going back to my own schooldays, I just remember the school doctor coming – I was probably about five or six at the time – and the idea that they would

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A look in your pants was a very powerful image and very embarrassing. Nobody ever does that to you. So children have a very powerful reaction to what happens in a situation of a physical kind. I remember the doctor coming round when we had illnesses and being examined and having a chest and feeling self-conscious and uncomfortable, because there is no other situation where, as a child, anybody outside the family examines you. So it would be easy to think, knowing that it was an endocrinological examination where somebody had to look at stages of puberty, that this was a sensitive girl's reaction to a normal physical examination.

Q Dr Eastgate told us yesterday that that was precisely what he thought the problem was with Miss A until he went on later in the sessions and something more came out.

A Yes. My understanding of it – and this was from reading the papers and before I had ever met Dr Eastgate or heard his views about it – was, from reading that very first interview, that at the end of that first interview I would still be thinking, if I was Dr Eastgate, that this girl is a sensitive girl, there have been concerns about her height, the mother had reported that she might have reacted to the paediatrician's insensitivity, I would be thinking along those lines, that this was something perhaps she felt taken into by her parents without her – we do not know, we have no information so far in the papers really except one remark, whether she was really concerned about her height. So the whole issue of that and the reaction to Dr Treasure, that would also make me think that this girl really did not like doctors and I would not be thinking at that point of abuse.

If I may say so here, because I may be asked about it later, in the first interview, I think it is very unfortunate that Dr Eastgate used the terms, "It happened to you", and, "When did you first feel uncomfortable?" because subsequently in the world of dealing with sexual abuse cases and sexual abuse investigations, those words have been used and associated with sexual abuse, but I would not have seen that – and I could not see how it could have been in Dr Eastgate's mind in that first interview. Obviously people use words like, "it" or, "When did you feel uncomfortable?" in trying to be non-directive in a sexual abuse investigations. You might say something like, "When did you feel uncomfortable?" meaning – it could be anything – but meaning that it was something unpleasant, or a bit unpleasant, rather than pleasant. So I think that connection has been made in the minds of people experienced in sexual abuse when it is rather sensitive questioning and rather open.

Q Then we have the second session on the 9th. We have that in tab 2, page 8. You have said it is not apparent from the actual record precisely how the allegation came out. Would you expect any remotely competent clinician in that sort of setting to ask a question such as, "Did he stroke your breasts?"

A Not at all. A clinician in that situation – and I think it has been very, very difficult for everybody really to judge what happened when we do not have an accurate account of it and we do not have a contemporaneous account from the girl – but there would be various ways of handling it leading on from her expressing her concerns about Professor X in the morning. You could approach it in various ways. You could approach it in a general way, "You mentioned he made you feel uncomfortable. What was it about the meetings you had with him that made you feel uncomfortable?" Or you could say something like, "Was there anything specific that

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A | happened?" There would be various ways, none of which would necessarily imply something physical at that stage. It could be about the way he spoke to her.

I would suggest that at that point the information we had was about his manner, not about the examinations, except that I would, as a clinician, probably want to know – and it is probably easier as a woman to ask a girl than it is for a male doctor – about whether the actual physical examinations had made the girl feel uncomfortable. I do not know whether Dr Eastgate did, but I would think that would be perfectly acceptable on the grounds that, as I was saying earlier, the expectation is, as it would be with – I have had daughters myself and my own memories of childhood – that girls would feel uncomfortable being examined by a male and there would be something, it could be a normal physical examination that had made them feel self-conscious – particularly if they were already self-conscious – and we do not know whether or not she really was – about her height and her size. The interviews, the eating problem and the interviews with Dr Treasure came later, so at that stage when she saw Professor X, we do not have any evidence of what her own feelings were about why she went to him.

I think the other issue is that we do not know how it was explained to her about bringing puberty forward. She was already in puberty when she first saw Professor X. That is evident from the Tanner Staging. To actually bring forward puberty and accelerate breast development at such a young age would be very difficult and the whole thing – we do not know how that was explained, either by Professor X or by her parents, as to why suddenly she was having to go through puberty faster. Personally I think it is a pretty awful thing for a child of that age have happen to her, with the bonus at the end as not being as tall as you would otherwise have been.

I have great concerns about the use of – I have treated patients – my other area of special interest is eating disorders and anorexia nervosa – and I have found that the girls with anorexia who have been offered oestrogens by physicians in relation to osteoporosis find them awful and do not want to take them. So there may be a whole lot of reasons why there were negative associations about Professor X.

Q | You are saying that in the mind of the clinician there are obvious reasons why the girl may have negative views about Professor X?

F | A | Yes. Which may not have anything to do with him, but were just about the whole process of treatment that she had.

Q | So it would be reasonable to pursue that. If the information was elicited was actually elicited by the sort of questions you have suggested, such as, "What was it about your sessions with Professor X that made you feel uncomfortable?", would you be content with that course?

G | A | I think it would also be perfectly appropriate in that – and we do not know what Dr Eastgate actually said – and it would probably be inappropriate not to, with a girl who is having difficulty talking, to say, "Was it the physical examination that made you uncomfortable?" It is leading and it is direct, but it is a factual thing that she would have had to gone through. I think it is difficult to know, because Dr Eastgate does not really give – I do not think people would normally give – a full account in a therapeutic interview of how information was elicited. Admittedly, when H | the girl did make allegations it would have been helpful if we had known exactly what

A he had said before she said it, but we do not know the context in which those allegations came out, whether it came out straightaway or whether it was in the context of an answer to a question.

Q You mentioned the girl's reluctance to speak, which we see historically. Way back in her background she had been uncommunicative. Would that affect the form of questioning that one might use, whether it be a clinical interview or even a formal, memorandum interview?

B A I think so. Well, obviously it would. I think you would want to be terribly careful. I have had a number of very different, silent adolescents to work with, often with eating disorders, often where sexuality is usually the most difficult area to talk to them about and the last thing one would do is bring up sexual issues unless the patient gives you clues. It is terribly important to listen very carefully to what the patient says, to notice their emotion, as I said earlier, and to try to pick up the clues to help them to talk in a very sensitive way. I think, as I said earlier, when you are asking about a clinical examination or a clinical appointment with a doctor, for a male doctor to ask a young, adolescent girl at a sensitive age who had difficulty talking about that, including the physical examination, would be difficult and would have to be broached carefully and tentatively. Having read Dr Eastgate's transcript of the morning session yesterday – I have not seen the afternoon one.

D Q His evidence before the Committee?

A Yes. And having obviously spoken to him, I would see him, if I was asked, as being more tentative in style. The kinds of doctors who do not do well with these adolescents are those who are very gung ho and ask a lot of very direct and intrusive questions and I think that probably Dr Treasure would have had to have done more of that in assessing whether or not this girl had an eating disorder – I know I do when I am assessing patients with an eating disorder – which could easily alienate the patient.

E Whereas Dr Eastgate came to this patient in a different way, through her school, building up very careful relationship with her which was quite strong, it appears, by the time she took the overdose and was admitted to hospital, when he had seen her a number of times. So I think there is a difference of approach and it goes back to the other point I made at the beginning about the difference between therapeutic work and assessment work. I think he was definitely in the therapeutic mode and I would not be expecting him to be asking direct and really intrusive questions. But I do not know, because I was not there.

F Q You would be surprised, having seen the way the doctor speaks and conducts himself, you say, if he had gone in feet first, asking that sort of form of question that anyone should know is inappropriate?

G A Yes. Sorry – can you repeat the question?

Q You said just now ---

THE LEGAL ASSESSOR: I think perhaps the problem with the question was that it was leading.

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A MR TURNER: I think it probably was. It was really trying to summarise what the witness has already said. (To the witness) You mentioned that you have looked at the transcript of Dr Eastgate's evidence and you have formed certain impressions of him based firstly on that and secondly on discussions you had with him after you had read the papers in this case.

A Yes.

B Q What impressions have you formed of his style?

A I would see him as a sensitive, cautious clinician. I think it is ironic really that he has been brought before this Committee for not being cautious, which was primarily I think in terms of contacting social services in this case. But from the areas of the clinical interviews that I have read – and again, we have the bare bones of them, but we have a lot more information of what led up to them, so it gives a sense of the quality of it – it does not seem to me that he would be the kind of person who is blinded by philosophy or anything which would guide his practice and that he would be somebody who would be thinking about his patient foremost.

D Having said that – and I think I started to say it earlier – I was actually quite horrified by his workload at that time. He would have to have so many patients in his mind, of which this girl may have happened to have been the most difficult one that week or two weeks, and she proved to be even more difficult subsequently. He had a huge case load, so in a sense he would not be looking for – the bias would be in a busy doctor like that to miss things or to not do things which would be more important and in my view it was more important that he sought advice and made sure this case was handled properly, spoke to the nursing staff, all of those things, than the detailed – he should have recorded more detailed accounts of the interviews, there is no doubt about that – but he was balancing what he could do possibly in a 24-hour day, I would think, given the amount of time he had, making sure he saw the girl frequently, because, as I heard from the evidence yesterday morning, his normal practice would be to see his in patients less frequently. So to have to squeeze in twice a day appointments on top of a very busy workload is very difficult.

E Q I asked you about someone coming to a case and looking back over it and being asked to comment on the actions or inactions of a clinician. Does the subsequent critic in that position in your view have any advantages or disadvantages over the clinician at the coalface actually dealing with the case?

A It depends on what you mean by advantages. It also depends on who the person looking at it is, because I think it depends on what you are looking for. What I was asked to look at was to look at the papers in this case and to decide whether the doctor had acted appropriately or not ---

G Q Can I just ask you to pause there? You have read the papers and formed opinion before you had ever met Dr Eastgate.

A Yes.

Q Although your report which the Committee have was written after you had met Dr Eastgate.

A Yes. I had met Dr Eastgate at a meeting earlier in the year.

H Q I think you had met him certainly in meetings with lawyers.

A A Yes. Only on one occasion before I did that report and it was some time previously. I do not have a fresh view of him in my mind because I had met him earlier in the year and the timing of all this was not clear. So I only met him after I had prepared this report.

Q Did your opinion change after you met him, or did it remain the same?

B A My opinion of him has remained the same. I think reading the papers, you cannot really tell whether – especially when you are focusing on those interviews – the style of a person’s interaction with patients and I think my impression of him is that he is more cautious, more honest, more self-critical than I would have got the impression in terms of the papers and having a much bigger caseload than I ever dreamed that somebody would have at that time.

Q You were present in court throughout Professor Zeitlin’s oral evidence.

C A Yes.

Q In general terms, do you agree with the criticisms that he has made of Dr Eastgate, or not?

D A No. It is difficult to say. Of course, one would agree that it would have been preferable for there to have been more detailed notes, but by not having the ... You were asking me before about how – and I feel that I became side-tracked and did not fully answer the question – one comes in and looks at people’s work. I think if you looked at any child psychiatrist’s work, as you have already asked me, you would find errors in our record keeping and correspondence because we are all far too busy and have far too many demands upon us. It is a question of where the priority lies and how one uses information. So, for example, there is a difference between writing therapeutic notes which are for your own purposes and correspondence. What we do have is a good set of correspondence from Dr Eastgate and many child psychiatrists who are busy would adopt Dr Eastgate’s practice of recording a lot of information through correspondence which is for other’s consumption and that is what we see here. You see very little of his private recording which was the interview notes of the clinical sessions which have come to be so important. That is not unusual if you went to an adolescent unit. Obviously, with clinical governance coming in the late 1990s and the last few years, there has been much, much more focus on record keeping for all cases in medicine, not just psychiatric cases. Certainly in the mid-1990s, it was not the habit for every interaction between patients and, whether it is doctors or nurses, detailed accounts of every conversation to be recorded in the clinical notes and I think it would be very difficult, even nowadays with the attention, for that practice to occur. People have to make a selective amount about recording but, in those days, I think practice was not as tight as it is nowadays.

G Then you were asking me about Professor Zeitlin’s evidence and his views about those record keeping.

Q I asked you generally first of all, I had not descended to any particulars. I just asked you generally whether you agreed with the criticisms expressed by Dr Zeitlin and I think what you have said so far is that of course it would have been better if there had been more detailed notes of the sessions.

H A Yes.

A Q How would you judge the seriousness of the lack of more detailed notes in the context of the circumstances Dr Eastgate was in at the time?

A It has been very, very serious for Dr Eastgate because he would not have been here, in my contention, had he written a more detailed account, but that is because I have come to a different conclusion from Professor Zeitlin from the information that I have read. I know that there is some sloppy note-keeping which we referred to later about talk from the nurses about abuse and about Dr Eastgate himself writing that letter to the mother about Miss A and, instead of saying “alleged abuse” or having a qualification about abuse now ---

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Q Something you did this morning, as I pointed out.

A Yes.

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Q I think there is a document you may not have seen yet because it was only produced yesterday: a note of a clinical meeting between staff that had taken place on 15 July 1996. Can I show you a copy of that. (Same handed)

A I am looking to see what date this was.

Q The 15 July 1996.

A So, this was prior to the strategy meeting?

D

Q Yes.

A It was the Monday after.

Q It was the day before the strategy meeting. You see first of all the essence of the history and how Miss A came to be there, the present situation and then something about sexual abuse but the word “alleged” appears in front of it.

A Yes. I am sorry, you were talking about ...?

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Q I was talking about the seriousness of the shortcomings as we see them now in the note-keeping and you said that of course it was serious for Dr Eastgate himself, but how serious would you regard the shortcomings in note-keeping from an objective point of view at the time and in the context?

A We have to think about the girl in this, the girl’s interest. The primary issue for her was that she had alleged what may have been abuse by Professor X but was no longer seeing him, so there were no implications of what she told Dr Eastgate for her in relation to any further episodes or contact with that doctor. The issue was – and I think this was the one that obviously troubled Dr Eastgate and I think appropriately and professionally – that, from what she told him, it sounded as though this needed investigation or at least discussion with others because there may be concerns about other children. So, his concern was not that of the girl’s concern. So, he had a very difficult task.

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In relation to note-keeping, you would have to think about whether it would have helped in the girl’s care to have had more details. Dr Eastgate told the police and social services at the strategy meeting – I am presuming because that is what he said – a more detailed account of what the girl told him and how she told him. His problem is that he cannot remember the details now. At that time, the important thing was the distress and obviously the parents were naturally concerned about what the implications were for this girl were there to be any pursuit of the allegations, any

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A investigation. That is the problem. It is not her clinical care, it is the implications for her of pursuing any allegations. The police would have had to investigate it, they would have had to interview the girl and they would have had to interview the other witnesses, the potential witnesses which were the mother and grandmother, and they would have had to interview Professor X and make any other inquiries. The issue for helping them is that it would be very important if there were to be a criminal trial or GMC proceedings in relation to that.

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Q GMC proceedings against Professor X?

A Yes. In that way, he could be criticised especially in relation to GMC proceedings because the GMC would not have how it came to light as far as that doctor was concerned, they would only have the information with the police. You have to think about how that harms the girl. Although we do not have any information about how much she knows of what is going on here – obviously there are issues about the press knowing it – any proceedings might be distressing and disturbing for the girl. There is also the issue in this case – and I am sorry, I am being a little convoluted here – that she has a private relationship with Dr Eastgate. He has been quite clear, as I understand it, about what he is telling other people, telling her that he will only tell other people with her knowledge. So, having detailed records which, if this were going to go any further, would assist an investigation, but I think he would have to have her consent unless, as we have been discussing these procedures, he felt that the public interest was such ... He would have to have absolutely clear-cut evidence from her of something that would require further investigation and that would be in the interest of protecting other children for him to override her consent and disclose her clinical records to others and I think that, for any child psychiatrist, as in the case that I gave the example of earlier many years ago of where I did not use a girl's name because I did not have her consent but wanted to get as much information to the police in order for the protection of others, it is possible.

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I do not think that a doctor could ethically override her consent and release her records in order to investigate Professor X unless there was a much more substantial allegation that it would be easier to prove and the chances of that are very, very unlikely and the Committee here will know how difficult it is to prove what a patient says against a doctor, even when it is an adult patient. So, in terms of the public interest – and there is a public interest in this case – that is different. That is about how we, as child psychiatrists, should handle allegations which come up in therapy. I think that is what this case is about. In terms of the girl and the protection of other children, I do not think that the lack of detailed recording was a problem, given that Dr Eastgate told the police and other professionals at the strategy meeting what the girl had said to him.

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The problem is that we have two experts and you could get 10 experts in this room and you would find us all having different views about this case and how it should be handled. My view is, for what it is worth and I do not want to be dogmatic, to say that there is no right way, that there are just better ways and worse ways and that we have to try and do our best in these very difficult cases. I think that is probably what the majority of experts would say. I think that Professor Zeitlin – I have read his report – really does believe that there is a correct way and I do not think you can say what that correct way is, unless you are in a position as this of the clinician with the

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A relationship with a difficult patient and, even if there were a correct way, many of us would err from it because of the difficulty of these cases and I am sure that, in all of our clinical practice, we all sometimes say or do things that are not ideal. It is a complicated area, especially this area, to manage.

Q If it were said, "It would have been better to have had more detail in the notes", is it, in your view, understandable or not that there was not more detail in the notes?

A It depends on whether you are trying to think about it from an understandable point of view in terms of trying to put yourself in Dr Eastgate's shoes ---

Q That is exactly what I am trying to ask you.

A With all the pressures. One can see those as excuses but they are actually very real. I know that I have left a whole pile of clinical correspondence because suddenly I have had to be here for most of this week and that correspondence will not be as good as it would have been had I done it straight after I had seen my patients. One is always under those pressures. I am sure that Dr Eastgate neglected some of his other patients during those two difficult weeks and subsequently. We all do things that are not ideal practice because we only have our own resource and the time that we have available and, if we get to a time where we are too exhausted, then we also have to think about our families. He could have stayed every night and dictated a detailed account of each of those interviews, but he had his family, his patients and others to think about. That, you could say, is an excuse. In terms of what one would have expected, I would have liked to have seen an account of the beginning of that interview on 9 September.

Q The 9 July, the second interview.

A Yes. The interview of in what context the girl said that the Professor stroked her breasts. That is a very important piece of missing information here and I do not think any of us should be judging this one way or the other because we do not have sufficient information to know whether it was a spontaneous allegation or whether he had led her in some very direct way. As I said, I still think it would be appropriate – and I think it is easier for a woman – to ask how she felt about the physical examination. You could say that was leading but I think it would have been entirely appropriate. If she were hinting that it was not just his brusque manner or other things ... There were lots of things that could have been explored. Did he explain why she had been put on this medicine? How much he had explained things to her. There would have been a lot of questions that he could have asked to facilitate her talking about what it was that Professor X had said or done that made her feel uncomfortable, all of which we could then have looked at with the benefit of hindsight and we could equally well have been sitting here saying, "He led her to it because he asked her about the physical examination."

I think that even had we had a more detailed account, it still would have been possible for different expert opinions to have a different view about it. That is what happened with the advent of video recording for Memorandum interviews and clinical interviews in that what happened was that everybody with greater expertise and less expertise sat around poring over the details of these and commenting on the techniques of the questions that were being used and lost sight completely of the child

A in the process. That is what our job is. It is to think about the child, what is in their best interests and to be sensitive and responsive to them.

Q What, as you see it, should have been Dr Eastgate's first priority in those days we are looking at during July 1996?

A Her.

B Q You have spoken about the difference between the therapeutic session and an investigation proper with a child.

A Yes.

Q What, in your view, are the attributes of a good therapist in a clinical setting?

C A There is research in this by Truax and Karkov: the neutrality, being non-judgmental, warmth and taking the patient seriously; being very sensitive to what they say and noting their emotional responses, and the focus of one's work really, if you are dealing with a young person who has either disturbance of mood or disturbance of behaviour, is greater understanding of the patient and helping the patient to understand themselves and their feelings and relationships better.

Q Can I just ask you one other matter about the second session on 9 July. Do you have it in front of you: tab 2, page 8? Would you in any event have expected verbatim records to have been kept?

D A Not verbatim. I would have expected ideally ... The previous interview, which is the morning of 9 July, is not by any means a verbatim account, but I would not expect any busy child psychiatrist, unless it was going to be clear that it was going to be used in evidence in a court, to have written a greater and more detailed ... Ideally, the account of the afternoon of 9 July would be of a similar sort of detail of the morning session and, as we have been experiencing here this week, it has been much easier to judge that interview than it has been to judge the afternoon of the 9th.

Q We know that the afternoon of the 9th was in effect an extra session that was put in because of what had happened in the morning.

A Yes.

F Q Would you expect, whatever the detail, it to be written during the session or after the session?

A Afterwards.

Q Looking at that note, the latter part of the summary says that Miss A felt she was probably responsible for what happened. If something of that sort had been indicated by a patient in this sort of context, what should the clinician's/therapist's reaction to that be?

G A In this girl's case, she had alluded already in clinical work to feeling that things ... I cannot remember the reference for it but it seemed to be that she felt that things happened to her and somehow she was responsible. It is also very common in abused teenagers and children and it is very common in depression. There would be a variety of reasons why she would see it as her fault. I think the other thing is that the fact that she felt responsible for what happened indicates – and I am sure that this is what Dr Eastgate was picking up on – that something more than what happened usually --- She experienced the interviews with Professor X as somehow happening

- A outside the realm of normal medical practice because she would not have said that if it had just been an ordinary quick physical examination. Hopefully – she was an intelligent girl – she would have been able to have said, “I did not like what he did and I felt very embarrassed”, or whatever it was, “but I recognise that that is what doctors have to do”, as was my own experience and my children’s experience. But she said she did not know what doctors were supposed to do, which suggests that
- B something happened that was --- We have talked about putting callipers on her arm – was it her arm or her back? – to measure the skinfold thickness. Again, that was odd. I am not saying it was an odd practice for an endocrinologist, but it would be odd to a child. There might be other things. Children are normally reasonably comfortable and expect to have height and weight measured, but there was something about it that caused her anxiety, and she had lost her bearings. She was not able to say, “He
- C listened to my chest and obviously he had to pull my bra down and it felt uncomfortable” or “I felt self-conscious”, or anything like that; and she had already said about the stroking of the breast. It would be very important, under those circumstances, to help her to understand that her feeling of being responsible was her feeling and not related to anything that she had done wrong. How could she have done anything wrong by being examined in a clinical interview? It would be very important that she was reassured.
- D My interpretation of that very shorthand note “It sounded wrong to me” is, of course with the benefit of hindsight, that it should have been there but when he suggested that what she had said sounded wrong; that was really the issue. Whether or not what she told him was true, that the professor had stroked her breast, or that however it was that she had experienced what had happened in that consultation as being uncomfortable, whatever she had told Dr Eastgate, it did not accord at that time with what he would have expected, and so he had to say, “It sounded wrong”, I think.
- E My question about the judgment – and this is where we could all look at errors of judgment – is whether or not he could have waited and had another session and said that to her and got more information, but you can always do it with hindsight, that is the problem. I think that it would be reasonable to expect a psychiatrist to be quite shocked, to have to contain their own surprise and shock and think, “Have I got to be doing something here?”, while trying to be patient with the child. It is a bit as we
- F talked about in some of the papers where we talked about containing your own anxiety or not revealing things to the patient. As professionals, we all have to try not to, but he might have felt pressured to think, “I’ve got to do something here”, and felt overburdened about getting her co-operation, so that is why he talked about worrying that he may have done it to other children, as well.
- G Having said that, one of the things that I have experienced with girls – and I talked about it, whether it is the alleged rape, which we talked about earlier – when patients are abused, even in a one-off horrific assault, it is not in their mind. They want to put it behind them; they want to close it off; they do not want to think about it. It is quite a shock to them when you remind them that actually we have to think about public safety here. For example, in that case I was the one who persuaded the girl to consent to genetic material going when she had a late termination of pregnancy, but it was for the public interest that I did that. That was intruding on her experience and
- H she did not want it. She did not want there to be a trial or the person to be caught

A because she was very frightened of what that would all mean. She just wanted to close off and forget what had happened.

Q Did Dr Eastgate have any duties here other than to her if he had heard that Professor X had, on the account she was giving him, behaved inappropriately?

A Yes. As I said earlier, he had a choice. He could have sat on it a bit longer. I think that probably at that point, as a responsible doctor, he was a bit overburdened by this knowledge, this surprising intrusion in his clinical work of something that he had to think about and take seriously because of ---

Q My question was: did he have duties to anyone other than her as a result of what was said?

A Yes, he did. That is what I am saying. That is what he was, I think, troubled and burdened by at that point. He had to think of ---

Q Duties to whom?

A --- other children. The other duty, which has got completely lost in thinking about that, is that he had some duty to Professor X. If this girl was making clear allegations – and we do not know how clear they were – about his practice, he had a duty to handle it well and responsibly in fairness to Professor X, as well. Not that that should be the first priority, but it needed to be addressed. If Professor X had acted inappropriately, then that needed attention because of his professional career and professional practice, so there was a duty, even if there was nothing that could be brought to the GMC or anything else. If he had not done anything that was inappropriate but had a brusque manner and made people feel uncomfortable, then that also needed to be thought about, so he had to be very carefully evaluating in his mind from what the girl said how seriously to take what she had said.

Q I ask you to take up the file containing the Wiltshire multi-agency procedure guidance document and turn to tab 2, page 49. I draw your attention to paragraph 2.1.4:

“Let the child ... know that you take the information seriously and that the child is not to blame ...”

F How does that fit in with the note for that second session on 9 July of what Dr Eastgate says his response was when the child told him that Professor X had behaved in the way we see described there?

A It fits very well, really. He did not use the words “It’s not your fault”, as I understand it, but he may have done as part of that thing. I think the important bit is that he was taking it seriously. Whatever the quality and detail of what she gave him, he had – and I think it is terribly important – to take it seriously. One counsels that sometimes with parents, for example. If a parent hears that their child has been abused by somebody, either inside or outside the family, it arouses tremendous emotions and parents can react in different ways, by dismissing it or by being furious and wanting to charge in and do something. To hold them and contain them and to have to sit, as we do as professionals, with doubt; he had to retain doubt throughout this whole process but at the same time appear to be taking her seriously. And that is the same thing, whoever you are, if you do not know whether abuse has taken place.

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A It is very rarely ever proven, especially these days. A parent, a professional, or anybody, has to appear to take it seriously, even if they find it impossible to believe.

Q The heads of charge in a sense identify a series of decisions that the practitioner had to make in the management of this case.

A Yes.

B Q In essence, perhaps, they can be broken down like this. First of all, “How should I, as the practitioner, conduct the session in terms of style and question?” Would that be age-dependent and intellect-dependent as far as the child was concerned?

A Absolutely, yes. As you are working with a patient, you have an idea of what works with the patient gradually, and I think the best therapists will vary their style in response to the patient. You do not go into an interview with “This is how I’ve got to conduct it”; you learn it in that delicate relationship that you have, which develops. Obviously, then you get thrown something that is completely surprising, as happened in this case, and obviously that can jeopardise the kind of way that you are working with the patient because suddenly there is another element to it.

C Q Changing the dynamics of it?

A Yes.

D Q Is that question, first of all, in any event, “What style, what approach, what form of questioning shall I use?”

A The thing is, I do not think we think it out, I really do not. When we are very experienced practitioners, we work because of our experience and it is quite hard. That is why, changing gear and doing something different, suddenly you are having to do it consciously and think it out, and then you can lose the patient in the process because you are having to do it, so that is very, very hard. I disagree with Professor Zeitlin about the ease with which that is done. I think it is a very difficult part of professional practice. We are talking here about a very difficult girl who had refused to see a professor in London and who had gone to see Janet Treasure, who is very experienced and whom most people queue up to go and see, and said she would not see her again, and who everybody was finding it very difficult to deal with. We are talking about somebody who was very difficult. To some extent you feel your way, that is how I would describe it, but you are bringing with it all of the experience that you have, like picking up on – as I thought he did very expertly – little things that she had said. He had made notes of very key things that she had said that were possibly important in her case so that he could help her focus on some of those things.

E Q Another decision to be taken was “Should I make verbatim or even contemporaneous notes at various different stages in the process?”

F A Yes.

G Q Is that a further decision that has, either consciously or sub-consciously, got to be made?

A No. I think that we should be doing it consciously, but on the whole, with a busy practitioner, it is more the case with the paperwork that we have a fairly sort of routine way of approaching our paperwork. As I said earlier, I thought that

H Dr Eastgate’s general approach seemed to include quite a lot of quite detailed

A information about issues in his clinical correspondence which served to help him in his clinical work, which is reasonable, and I think a lot of busy practitioners do that. They look at the last letter that they wrote about the patient when they next see them, and it depends on the nature of the problem. But then, if you are doing more therapeutic work, and more frequent work – and I think that nowadays child psychiatrists are doing less of that than they did in the past, either family therapy or individual therapy, but in those days, in 1996, they were doing a lot of that work themselves – then they probably would not write detailed contents of the sessions down every session, as I have said earlier.

Q You have dealt with that.

A The question I was going on to is: when do you deviate from what is your normal practice? That is the issue here. My contention would be that Dr Eastgate, after the morning of the 9th – I do not know when he dictated that note – recognised that there was a deviation here, some important clues that were going to help him with his work. He had not got abuse in his mind at that point, I do not think; there is no evidence that he had. He actually wrote a more detailed account of that interview, which led into the allegations she then made. I think the big thing that one could criticise him for is not having written an account of the afternoon interview of the 9th when she first told about the sexual abuse. But you would have to think about the context of that day, when he is running a six-bedded adolescent unit, and how many phone calls? I know that I do not ---

THE CHAIRMAN: You have made that very clear to the Committee.

MR TURNER: A topic I have not put to you yet is this. It was suggested to Dr Eastgate yesterday that there was a culture, as it were, of seeking to find, or look for, sex abuse in his unit. Have you seen any evidence of that?

A No, I could not see any evidence of it. I was not very happy about what I think was rather an inappropriate shorthand, “Abuse by the medic”, that the nurse wrote. It is a long time since I have worked in an adolescent unit, but obviously I supervise trainees who do and work closely with colleagues, and many of my patients have to go into adolescent units, so I am very familiar with their working. I am very familiar with what happens when a child who is admitted makes a disclosure of abuse. It is not what people in units want. They do not want to be having to deal with sexual abuse if they can possibly avoid it, any more than they want to deal with self-harm or other things. There are parts of working in adolescent units that are very stressful and difficult, so people do not look for it.

There is another side to the coin, that if you have a girl who comes into the unit with a history of sexual abuse and it has been quite clear or, for example, there are very strong suspicions, like gross sexualised behaviour, or something like that, where there is concern that the child might be at risk, might be in contact with somebody who is abusing them, or is really disturbed and having great difficulty talking about what has happened to them, then you might want to facilitate them to talk about it. But, in my experience, time and time again, when people do that before the patient is ready, it is often counter-productive because the patients can get more disturbed before they are ready to handle it. It has been my experience over a long period of time, looking at cases where you know when somebody has been abused but when they are able to talk about it --- For example, because I have been in my job for 20 years, I have seen

A people as adults whom I strongly suspected were sexually abused when I saw them as teenagers who have come back to me and they have told me about the abuse that they experienced. I have said, “Why didn’t you tell me at the time?”, and it was because they had their relationships with those people and actually to have opened it up would have meant affecting those relationships. It is again a very difficult area. I do think that sometimes people have tried to pursue getting people to talk about sexual abuse in a misguided way when the patient is not ready to do so.

B
Q Should Dr Eastgate have sought any further verification of the allegation that the girl had made before he went to consult Mr Evans of the Child Protection Team?

A My impression was that I do not think --- Again, we are so stuck by that interview of the afternoon of the 9th. I do not think he would have said to her “It sounds wrong to me” had she not said something in the context of whatever she was talking about did not sound serious. That was the first step. He made the step to say that he had to take it seriously, when she was not sure. But after that she did go on to describe more details. The timing of when he asked her – and again we are stuck without the note of it – the details of the layout of the room --- That occurred before the strategy meeting but we do not have a clear view of whether that was before he spoke to a social worker or not. You may have heard yesterday in evidence whether that was the case. I think we are in great danger if we are seen as the investigators, especially when there is therapeutic work. Once he had got sufficient information to arouse his concerns, his job then was to let other people decide whether or not they were going to investigate it. If we had enough information so that it sounded wrong to him, at that point to consult was appropriate. It might be that the person he consulted with said, “Well, it is very hard. We cannot really know what happened because the parents were probably present and everything, do you think you could get a bit more information about it before we have the strategy meeting?”, or he may have thought he had to do it, just so that the strategy meeting had a bit more to go on in which to decide whether or not an investigation was warranted. So I think it is a question of judgment really. I think again, with the guidance that we have from *Working Together* and certainly post-Cleveland, we were all terribly careful when the memorandum interview came in and the specialist teams were set up that we were not the investigators. Our job was the therapeutic work with the patients. We had, as a parent or as a teacher would have, the job of alerting the appropriate authorities that this might be a case of sexual abuse and describe how the allegation came to light, which he did verbally I am sure but not in writing. That was his duty. I think, once you suspect abuse, but particularly where it is abuse that has serious implications for other children, and it is outside the family, then it has to be investigated, if it is going to be investigated, by people very experienced in the evidential part of it. I personally feel to do more than he did would be, as we have heard the phrase, muddying the waters of what could be a police investigation. Could I just add to that? One of the other things that happens with teenagers is that they do not like to tell stories over again. I do not think this has really been considered so far. When somebody tells you something serious, or potentially serious, you take it seriously and acknowledge to the person that you are taking it seriously. The last thing you want to do is to go into great detail about what happened, if somebody else is going to investigate it because the chances are that when they investigate it, they are going to say, “Well, I have already told so and so, I do not want to go through it”, or they may not have the relationship with that person. In a way, if this girl was going to be making a statement to the police, it was quite important that she did it afresh and the police

A officer could seek the clarification in taking the statement that was needed to make it clear, if that was going to happen. In the event, this did not happen in this case and it did not go any further. So I think it is the job of anybody to say, "Are there sufficient grounds to take it", in terms of the consultation getting, and it is the seeking of advice which is the first step about whether it should be taken any further, like to a strategy meeting. You could do that very early on. He did not have to get as much information as he did before he spoke to them. I think it is a question of judgment in any individual case and the relationship with the patient, the timing of doing that. He saw it, and again I think the guidance talks about that with young people who are old enough to understand the importance of working openly with them and about doing it with her knowledge, once he had said he was not going to talk to anybody without her knowledge. So he had to feel he was at the right stage, and also that she was sticking with her story. That is also a very important aspect of this case. You could imagine a situation with a young girl who is uncomfortable in a clinical interview, not sure if the way it was handled was correct; the doctor takes it seriously, says it might have implications for other children. She would then say, "I may be wrong. Maybe I was just over-sensitive", and she would backtrack. If she did backtrack, then it would go no further. That would also be very important. The fact that I think he waited three days and had several contacts with her and she stuck to her story and gave more details was all the more reason for him going ahead at that point and get advice.

D Q In the conclusion paragraph of your report before the Committee you say, "In my opinion, Dr Eastgate's professional conduct in this difficult case was of a high standard and he put the interests of the patient first while considering carefully the implications for other children if he did not raise his concerns with the appropriate authorities." Is there anything you have heard since you wrote those words to cause you to change or qualify them?

A No.

E MR TURNER: The only other matter is to produce the copies of the CV that are now available, (D10 produced and circulated)

THE LEGAL ASSESSOR: Mr Turner, will you remind the witness that she is on oath and should not discuss this.

F MR TURNER: I certainly will, yes.

(The Committee adjourned for a short time)

Cross-examined by MISS GLYNN

G Q Dr Hall, you have given a range of evidence about a number of different aspects of this case. What I will do, if I may, is try to focus on some very specific elements. Before we look at the specific heads of charge, you have made some reference during your evidence this morning to your understanding of the doctor's workload and the pressures he may have been under?

A Yes.

H Q Did you know that he had accepted Miss A as a private patient initially?

A A Yes. I think I only actually appreciated that fully as part of this hearing, not when I prepared my report.

Q But it would appear that during the course of undertaking his duties at the hospital, he certainly would appear to have regarded himself as having time to undertake private duties as well in relation to the school which Miss A was attending? Were you aware of that?

B A I presume that would have been the case.

Q I think you would accept that all child and adolescent psychiatric consultants are busy. You yourself are busy?

A Yes.

C Q That unfortunately perhaps is one of the features of undertaking this sort of work?

A Being a child and adolescent psychiatrist?

Q Yes? One is busy. There is usually a fairly heavy workload.

A It varies around the country but I think things were much worse in terms of workloads in the mid-Nineties than perhaps they are quite today.

D Q You have said in your report, and indeed during your evidence, that this was a difficult case.

A Yes.

Q What is undoubtedly true, Dr Hall, I suggest, is that it became an extremely difficult case further downstream, if I can put it that way.

A Yes.

E

Q But, of course, you will understand that this Committee is looking at the outset of the case, if you like, at a very early period in July 1996, and specifically between 9 July 1996 and 19th, for the sake of argument?

A Yes.

F Q I suggest that when Dr Eastgate told the Committee yesterday that in effect Miss A was not very different at that stage from many other patients that he had seen, he was right?

A In terms of complexity?

Q In terms of the fact that it may be difficult to communicate with her; in terms of the fact that she was suffering from depression, self-harming and so on. This was not an abnormal case at that stage at all, was it?

G

A Not for in-patient work.

Q It would not have been an abnormal case for an experienced consultant psychiatrist working in this field of child and adolescent psychiatry at this stage?

A No.

H

- A Q Indeed, because there is potential for such cases to become complex where allegations of sexual abuse are made, there have been produced a number of sets of guidelines to assist people working in this field with making the correct decisions?
A Yes.
- Q Although they are not prescriptive, what they set out is principles of best practice, if you like?
B A Principles of good practice.
- Q I am sorry, I mean good practice In relation to this case, there has been a lot of discussion about the context in which Dr Eastgate was working. I think we are all accepting that he was working within a therapeutic context?
A Yes.
- C Q He was working within that therapeutic context throughout the material period that we are concerned with before this Committee?
A Yes.
- Q I am sure the Committee is very anxious not to engage in semantics here, but there comes a stage when one is working in a therapeutic context when information needs to be gleaned, and I think you have accepted that, in order to proceed with the treatment?
D A Yes.
- Q Whether you call that investigation or not, it does not really matter. We are not talking about formal investigation in this case using the *Memorandum of Good Practice* and so on.
E A Are you talking about in ordinary therapeutic work before issues around sexual abuse are brought up?
- Q What I am suggesting is that this case it not about formal investigation using the *Memorandum of Good Practice*. This case is about good practice within the context of therapeutic work?
A Yes.
- F Q Professor Zeitlin gave, I suggest, the clearest evidence earlier in this case about the relevance of that. What he suggested was that the elements of good practice that we have looked at – and we specifically have not put before the Committee the *Memorandum of Good Practice* which deals with a later stage of the investigation at this stage – and we have here apply to the therapeutic stage, just as they apply to any kind of investigative work with a child.
A In talking about the therapeutic stage, are you talking about therapeutic work?
- G Q Yes. Let me give you some specific examples to help. For example, the guidelines that we have seen, and I am not going to take you to them specifically, about not leading children would apply whether in a therapeutic context or in an investigative context. You would not want to lead the child to say something that it might not say otherwise, unless there are very exceptional circumstances requiring facilitation, such as a child with venereal disease or pregnancy or in grave danger that you have mentioned this morning.
H

- A A Sorry, you are talking about sexual abuse, though, now, not just ordinary therapeutic work? That is what I wanted to clarify.
- Q Yes, I am talking about situations in which you are undertaking therapy of a child and there may have been an allegation of sexual abuse.
- A Yes, that is what I wanted to establish, that you had got to that stage.
- B Q When we look at the principles of good practice, it is quite clear, is it not, that in relation to not leading a child, they apply equally to a child who may be making allegations of sexual abuse in a therapeutic context?
- A Yes.
- Q Unless, as you have made clear this morning, there is a special requirement for facilitation?
- C A Yes.
- Q Such as the child being in grave danger, which is not the position here?
- A No.
- Q There is also a principle that we have looked at in some detail that the interviewer should not transmit his or her opinion about what is being said that might influence the child in her perception?
- D A My reading of the papers, and we would have to look at the special sections again, was that they should not transmit their feelings, which is different than opinion.
- Q All right, their feelings.
- A And it is also about what the child has said.
- E Q Their feelings about what the child has said?
- A Not taking the doctor's interpretation of what the child has said, but taking what the child said at face value.
- Q And, very importantly, not to do anything that might influence the child to say or do something that might not be true. That is simply common sense?
- A Yes.
- F Q If we look at what the heads of charge allege here, perhaps it is worthy of some clarification. Head of charge 3 relates to allegations that Dr Eastgate has inappropriately led Miss A to say what she said at the first session on 9th. Head of charge (b) relates to a suggestion that Dr Eastgate has inappropriately transmitted his view or feelings about what she said to the child in a way that might have influenced her?
- G A Yes.
- Q So there is a distinction between the first session on 9th and the second session on 9th? Then we have head of charge 5, which is suggestions regarding notetaking, and head of charge 6 is referral. I want to ask you, please, about head of charge 3 to begin with. Perhaps you could take up a note of that which you will find behind tab 2 at page 7. Would you agree, Dr Hall, that the context in which one is interviewing a child is extremely important? The context, what you know about the child, what you
- H

- A know her specific problems are, what her feelings might be, and so on, is very important?
A Yes, of course.
- Q In a case where the child was very distressed, there were signs that she may have been or wanting to self-harm, she was clearly suffering from depression, she was clearly a very vulnerable child, is that right?
B A Yes.
- Q Although also highly intelligent, perhaps wilful?
A Wilful is the one area that I am not convinced about.
- Q Leave that to one side for the moment. Also, Dr Eastgate at the time had formed the view that she came across as quite almost frightened at times, as though she might be expecting him to be cross or angry or refuse to see her again if she said something that did not meet with his approval.
C A Yes, that was in the transcript from yesterday. I had not heard it until then.
- Q She was also described by Dr Eastgate as being somebody who was emotionally needy. Do you recall that – quite withdrawn most of the time, quite tearful at times, quite emotionally needy?
D A Yes, I cannot remember where that came from.
- Q That was from Dr Eastgate’s evidence yesterday.
A Oh, from the evidence yesterday.
- Q In those circumstances, of a girl who was looking for his approval in some way, or certainly not to attract his disapproval, an emotionally needy child, it is very important not to influence what she might say, would you not agree?
E A Yes, and that is why I do not see her as wilful because what I had read about her was that she was somebody who sought ---
- Q Let us not distract ourselves by that, if we may. Do you agree that it was very important in those circumstances that she should not be influenced by the interviewer?
F A Well, we always influence our patients in a sense by talking to them, but in terms of what you are getting at, influence to say things that were not true, is that what you are implying?
- Q Yes. I want to turn, if I may, to your report because you dealt with this at paragraph 9. (Same handed to witness) Perhaps I should also ask you about this. Were you aware that there is a volume of evidence that by this time, on 9 July, Miss A was steadily unfreezing, if I can call it that, in her communication with Dr Eastgate?
G A I have not had the impression that there was a volume of evidence to that effect, unless that came through in cross-examination yesterday afternoon. My impression was this was a girl who it was always difficult to talk to but she had clearly, as you read all the clinical interviews from when he first met her, been able to talk increasingly about various things that were important to her with Dr Eastgate, but I do not get the impression that she was --- “Unfreezing” is not quite --- I would not see her as frozen. I would see her as more withdrawn and uncommunicative, which is
H

A different from being frozen. Although he has subsequently said she was afraid, it sounded as though he had difficulty talking with her.

Q To give him credit, it would appear that by 4 July, he had made progress with her to the extent that she was willing to speak with him, certainly much more openly and fully than she had been before?

A Yes.

B

Q We can see that there are sessions, instead of being once a week, from 4 July on, there is a session on 5th, on 6th and two on 8th.

A Yes.

Q And then we have this session on 9th, so that is the context in which this session happened on 9th.

C

A Yes.

Q Indeed, on 4th, she had asked to see him because she was concerned about that coming weekend, it seems?

A Yes.

D

Q When one looks at what happened on 9th, Dr Eastgate has said that the reason this note is comparatively full, compared with the other ones that come later anyway, is because of the content.

A Yes.

Q It was important content. Clearly there were developments that were worthy of fuller note taking here?

A Yes.

E

Q Can I make it clear that there is no criticism of Dr Eastgate up until the end of the second paragraph, and there a number of questions have been put in that second paragraph, which have alternative answers, but relatively open answers.

A Yes.

F

Q Until we reach the question “Was it somebody in London?” and then there is silence, so at that point the family has been eliminated, the schools have been eliminated, T has been eliminated, and we have now reached the stage of London and silence.

A Yes.

G

Q As I understand it, what you are suggesting in your report was that for Dr Eastgate to go on to suggest to Miss A that it sounded as though it was someone in London and because it was neither family nor school and it was clearly somebody else, perhaps it was somebody medical, that that was logical and appropriate. Is that right?

A Yes, it is very hard to put oneself in Dr Eastgate’s shoes with the more detailed knowledge of the patient than we, sitting here, have, but the issue is – and Harry Zeitlin was asked about this – was it logical to conclude or to suggest to her that it might have been somebody in London when she was silent after that question, having, as we have heard, said “no” to the other questions. If somebody is silent, and

H

A that is part of the work of a skilled therapist, often it is because they are frightened of answering that question. If there had not been somebody in London, she would have said “no”.

Q Let us focus on the medical: the suggestion comes from Dr Eastgate, “I wondered if perhaps it was somebody medical”, and she agreed it was. You would agree, surely, that that is leading?

B A That is what I have said in my report, that that was a much more direct suggestion than the others so far. On the face of it, you could say, “Where did he get that from?” and if you did not know the patient already, it would be the last thing one would suggest, but the things that he knew about this girl that had upset her were what she had told him and what her mother had told him. She knew that she had been to two doctors in London, both of whom the girl had reacted to negatively and said she did not want to see again. It is unusual for children to have that attitude towards a doctor. Often when their parents take them to a doctor, they will say they do not like them very much or “why does he talk to me like that” or “why does he not talk to me and only to you?” or the sorts of things that children say, or have positive reactions about doctors, but to actually refuse to see them again is quite a strong thing. So to talk about London and it not being somebody in the family – and she was not in school then, one could argue it was other relatives or friends of the family in London, but he was not thinking about abuse here, he was thinking about what he knew that she had potentially told him she was distressed by. I think he probably was not even thinking, it was probably intuitive, he was picking up what he had known about the case and her mother had told him that she might have been sensitive to the Professor because he was brusque in manner and obviously there were concerns about her body and height and those sorts of things. So I do not think it at all incongruous of him – and we are not talking about investigating abuse here. This is what I think is the bread and butter of therapeutic work. We pick up on what we have picked up from the patient that might be of concern to them. Of course, if it was not somebody medical who had upset her – I mean, there were grounds for feeling that somebody medical might have upset her – if there were not any grounds for it, she would have said no, if it was somebody else she was thinking of.

Q Dr Hall ---

F A So I cannot see why that could be considered as inappropriate.

Q Dr Hall, the subject matter of this discussion with Miss A was people who had let her down.

A Yes.

Q People who she talked to or who had made promises and who somehow or other had then gone away.

G A She had also eluded, if I may say so, to somebody else. I think he was thinking about “let down” – that was my interpretation of it at first – but I think, having heard more evidence in the case and having thought about it more deeply, it may be that he was also picking up on the “there was somebody else”, because that was a clear thing that she had said. So he was trying to help her to talk about this area which was obviously distressing and difficult for her. I think the task is when we pick up with a patient that there is something there, we do not know what it is, that is difficult for them to talk about, then to be sure. That is important to the patient and

A their well-being. So you need to try to get to that if you can – and we are talking about therapeutic work, we are not talking about sexual abuse here.

Q Dr Hall, this child had talked in the past about the headmistress, about the death of B, about the issue concerning the pony, about her younger sister and about her relationship with her mother. They were all problems for her.

A Yes.

B

Q Do you agree that in the notes we do not see anything like this degree of direct questioning, in other words, eliminating, getting to the root of it by process of elimination? She seems to have been quite able to describe the problems with the headmistress and so on in the past.

A She had had some difficulty. She had had difficulty talking about a lot of areas of life for her. So it was not as if this girl was talking volubly about anything.

C

Q Do you follow the distinction between the notes relating to those other issues and the second paragraph on this page? There is a distinction, is there not?

A Yes.

Q It is quite clear that Dr Eastgate was dealing with a different situation now. He was dealing with something, someone, she had eluded to before that she had not been able to talk about, which was difficult for her and different. Yes?

D

A Yes.

Q Therefore it may well fall into a different category from the headmistress, the pony, the mother, the sister and so on.

A The only category we could assume is that it is somebody who it is more difficult to talk about, which is causing more distress to the patient and all the more reason in my view for trying to help her to talk about it.

E

Q Indeed, something which may have happened to her which is more difficult.

A That I think is not the case and that is where I differ from Professor Zeitlin and what I tried to say in my evidence before, because he talked about “it was somebody in London”, rather than “somebody” as a person. “It was somebody in London.” Somebody is a person and ---

F

Q Dr Hall, I am sorry to interrupt you, but can I just see if we can get to the root of this? On the face of it there is a distinction between what was happening in this session and what had happened in earlier sessions in relation to her numerous other problems with other people who had let her down.

A Yes. It was going into a new area.

G

Q Therefore it was particularly important to let her say what she had to say without influencing her, was it not?

A I think again this is the difference between therapeutic work and non therapeutic work. If you have picked up clues – and, as I say, an experienced and intuitive therapist will be picking up clues all along in work with patients about looks, anxieties, information that they have had – if there is an area of difficulty, I think it is quite acceptable for a doctor to try to help that patient into that area. There is no

H

evidence in ordinary psychotherapy – you do not say, “You have a problem with your

A father”, let us say. You would be picking up that there was a thing and would be asking about feelings in relation to the father, let us say, if you have picked up that there is some distance between them, for example. So in a way you do need to guide patients into the areas which you think are important to them which are difficult. I do not feel he had abuse in mind, although the way this is written, it could be interpreted as that way, because, as I have said, the language smacks of some of the words that have been used in trying to help children talk about abuse, but it is absolutely appropriate to talk about areas which you pick up from the patient are important and difficult for them.

Q You simply cannot say what he had in mind. You have made reference to the language, which is the sort of language which is used when one is dealing with abuse cases.

C A Has come to be used. In terms of being more open, is what I am trying to say, not directive. It is not abuse cases where people have been over directive, it has been abuse cases in order to avoid being directive. By using words like “uncomfortable”, it is not saying, “He hurt you”, or “Upset you”. Using the word “uncomfortable” is a mild word which is slightly negative, rather than saying what you liked. So that is how it has got used in abuse cases. So I think people are making that connection erroneously, which I do not feel was the case here.

D I do not honestly believe that Dr Eastgate had in mind sexual abuse. If you suspected sexual abuse, you would not have pointed to that person. So, for example, I think he got into territory that he had not expected to get into. I am thinking about many patients who one wonders about, whether or not they could have been sexually abused. You might try and help them talk about all their relationships, but you certainly would not want to be focused on the person who you thought might be the abuser. You would be wanting to talk about all their relationships, so that you would get a sense of the quality of the different relationships.

Q By the beginning of the third paragraph, there are a number of alternatives that she could have been referring to, were there not? There was perhaps somebody involved in childcare in London, a babysitter or a nanny?

A Yes.

F Q She might have been on holiday with a friend somewhere where something had happened to her which made her feel let down.

A Yes.

Q A nanny might have left and made her feel let down.

A Yes.

G Q Anything could have happened. The word “uncomfortable”, would you agree that in the context of a conversation about being let down, people who had gone away, whether it is died or retired or whatever, is a very loaded word?

A I think he was using that word because it might apply to how you feel in a medical examination. Many children feel uncomfortable when they are examined by doctors, when they are being brought to doctors to talk about their height. The doctor here had evidence already from the mother that the girl might have felt uncomfortable in this doctor’s presence because of his bedside manner. So to me, sorry, I just do not

A see how being sensitive and using the information that you have is inappropriate here. If it came out of the blue, I would agree, you would be very surprised. Why had he somebody medical in mind? But it fits with this case. It just seems logical really and any practitioner who was being thoughtful about the case with a girl who found it difficult to talk might make the assumption that it would not be easy for her going to these doctors. He had evidence that she had refused to see doctors and, as I said, how many children does one encounter who have actually refused to see doctors and who are obviously in need of a seeing doctor?

Q You have said that the last thing one would want to do would be to find sexual abuse where it might not be there. Is that an accurate summary?

A Yes.

C Q This girl had been an inpatient for almost a month by 9 July. We know that.

A Yes.

Q She had been presenting with a number of problem which Dr Eastgate on the face of it at that stage – and there is no criticism of him at all – was not finding easy to treat, because he could not get to the root of it. Do you accept that? He had made little progress by 9 July in terms of the treatment of this child.

D A But this is commonly the experience of young people on inpatient units. It is very interesting how very often when young people come in, they actually get worse when they are on the inpatient unit. You could ask why: is it the influence of other children, or is it that they no longer have to conform and fit it with the rules of school and other things and their distress comes to the fore, because that is what the inpatient unit is trying to do, it is facilitating helping the feelings that are there. So I do not think people are looking for a cause. One is trying to understand the patient and there is certainly enough information that we already had before 9 July of things that distressed this girl. She was an intelligent but very depressed girl, it sounds like with very low self-esteem, which may have been secondary to depression or may have been there beforehand. The job of the therapist is just to help her talk about her feelings. It is not looking for one cause, it is helping understand her and for her to understand herself.

F Q But it is unrealistic to suggest that sexual abuse would not have been in the back of his mind. I think you have accepted that already in these circumstances.

A It always has to be in the back of one's mind.

Q He would have been looking for a differential diagnosis, having had this child as an inpatient for a period of a month and having been treating her before that.

A But sexual abuse is not a diagnosis. He had the diagnosis at that point in time, which was of depression.

G Q I do not want to get involved in semantics here. He might have been interested to find out what might be the cause of the depression, which was the diagnosis.

A That is what he was trying to do with her, yes. But I do not think ---

H

A Q Of course nobody wants to find these things, but as a professional you are interested to find out what might assist you in treating and helping the patient, are you not?

A Absolutely.

Q Whether you are a cancer specialist or whatever you are.

A Absolutely.

B

Q You do not want to find it, but on the other hand you are interested in finding out whether it is there.

A Yes.

Q That would obviously have been a subtext in Dr Eastgate's mind by the 9th, I suggest, one of the many things.

C

A Sexual abuse, you mean?

Q Yes.

A It could be a subtext, but one does not normally look for it in relation to a relationship with another doctor. So I think in the focus of this interview, he was not looking for it there. If one has it in one's mind – my experience with difficult adolescents is that it can be somebody and is usually somebody who has an important relationship with you which causes great disturbance and distress. Children who have had normal relationships and are exposed to one abusive experience, which is more common than we are aware of, by somebody who is not an important person in their lives, might find at the time that distressing and difficult to deal with, but on the whole are not fundamentally disturbed by it.

D

So my contention is that while you do have to have sexual abuse in the back of your mind when you are working with difficult and disturbed adolescents, one does not have in the mind that kind of abuse with people who are not important figures in their lives, as she alleged here. One has to have in mind that there might be abuse in terms of more significant relationships in her life. Again, as I said earlier in my evidence, you have to be quite patient, you have to wait until the patient is ready to reveal it, but obviously one is probing all the difficulties in people's relationships. For example, patients with eating disorders – this girl did not, as it happened, have a classical anorexia – often find it difficult to be critical of anybody, tend to take it all on their shoulders and blame themselves. So one is also having to help them to be a bit objective about relationships.

E

F

Q If I could break down the heads of charge. At the moment I am concentrating on head of charge 3, which is leading. I will look in a moment at head of charge 4. It may be appropriate – I think we have all understood what your evidence is about head of charge 3 – to move on to the issue of transmitting opinions or feelings about what has been said about head of charge 4. It is quite clear from the evidence you have given already that once an allegation of sexual abuse has been made, or something which might be sexual abuse, you have to change and use a different approach. That was your evidence this morning.

G

A Yes. You have to use a dual approach instead of a single approach.

H

A Q I think what you will accept from that and is not challenged, as I understand it, is that thereafter there is an even greater emphasis on not influencing the child in any way.

A Well, it depends on what you mean by influencing the child.

Q Would you want to influence the child in what she has to say about what happened to her?

B A You would in certain ways. For example, it is not the case here, but supposing a child told you of something terrible occurring, let us say, in the situation that they were living. She told you with great conviction and the details and the demeanour of the child and the way she presented, you felt very confident that something serious was happening. You would need, again, if it was an adolescent like this, to gain their confidence. You would have to talk to them how it may be important to breach confidentiality. Those are things that influence. You are going to have to persuade a child.

C Q Can we stick to the facts of this case, if we may?

A You were asking me in general about influencing the child.

D Q I do not want to create differences between us where there are not any. Can we establish where there are similarities or indeed your evidence accords with Professor Zeitlin? Where you are dealing with an allegation which may be one of sexual abuse, it is very important not to influence the child and say something which does not reflect what actually happened to him or her.

A Yes.

E Q To that extent, where you are dealing with an emotionally needy child and one who is concerned not to attract the disapproval of the interviewer, you would not want to impart to that child the interviewer's own views of whether or not the incident happened, would you? You would want to take it seriously and you would want to make sure that the child should not blame herself.

A Yes.

Q Those are the imperatives.

F A Yes.

Q That she should not feel in any way to blame for what she is saying.

A Yes.

G Q I think we have looked at an extract from the literature about that. If I could ask you to turn to tab 8, page 2, please. You see, one of the things he could have said – and you understand the allegation here relates to the last sentence:

“She was surprised when I suggested that not only did it sound wrong to me, but I was worried that he may have done it to other children as well.”

That is where the criticism attaches.

H A Yes.

A Q It would have been quite easy and, we suggest, appropriate and correct practice for a consultant psychiatrist, to have said to Miss A at that point, “It is not your fault that you felt uncomfortable with Professor X.”

A Yes.

B Q That would have been wholly unjudgmental, would it not? It would not have imparted any view on the part of the psychiatrist. It would have been clear that the psychiatrist was taking her seriously and seeking to reassure her.

C A Yes. But she had gone on more than to say she had felt uncomfortable with Professor X. She had said at that stage that her breasts were stroked. We do not have a full account of the words she used and everything else, but, if I put the question back to you, is it not also appropriate to say, “It is not your fault that Professor X stroked your breasts?” If that is what he had said, then you would be taking it at face value. It is important that you do not say, “He could not have stroked your breasts”, or, “Maybe he was just listening to your heart.” That would be influencing her. You would have to be saying the same thing. You are taking her seriously. So that is the first part of it, that you would say it is not her fault, but it would not quite fit to say, “it is not your fault that he stroked your breasts”, because it does not fit quite so well and she is saying she did not know what doctors are supposed to do and she was to blame.

D Q At that point, which is the very first time she has made this specific allegation, there is, I suggest to you, no point and indeed no reason not to, to mention the stroking of the breasts at all. What is important is to reassure her, to make it clear that you are not blaming her and that she should not blame herself for what has happened, more importantly, and then let her confirm, elaborate upon what she said in due course.

E A I agree. That would be one way of handling it and that is what I was trying to say this morning. If you look at it with the benefit of hindsight – and I look at it and I think, “”What would I ideally do under these circumstances?” and we do not have much of the content of the interview here to go by – you could argue that all you needed to do in that session was just listen. You reassure her where she needed reassurance. Then you go away and think about it and think about the implications of what she has said and whether you ought to be taking further action. Then you might want to decide what he did, which means obviously having to work openly with her.

F If he was to take any further action which would involve her, he would have to tell her why, and that means that he is actually saying that what she has said sounds wrong enough for him to have to take it outside the doctor/patient relationship.

G If any criticism could be made that it is an error of judgment – and we cannot know what any one of us would have done in the circumstances – it is that you could think ideally that maybe he would have waited and talked to her the next day. But as I said earlier, I think that the doctor was facing a very difficult task. When you are suddenly landed with something that you think, “Gosh, how am I going to deal with this?” while trying to talk to the patient. I feel he may have felt burdened and I think adolescent psychiatrists, who work more with adolescents than, say somebody like myself, are more conscious of the issues, especially on an inpatient unit – and the nurses have to act by this – about not keeping secrets in their work, of actually being very open about who communicates what with whom and that is what I think his

H

A anxiety which might have been premature, but we do not know. We do not know how distressed this girl was and how confused this girl was.

Q I am sorry to interrupt you. I know you are very keen to explain this in detail, but I think the Committee has probably understood what you are saying. May I just put some specific points to you and then ask for your views about them? You have given evidence to the Committee that Dr Eastgate had to say it sounded wrong. As I understand ---

A No, I am sorry, I did not mean to imply that he had to say it. He had a choice.

Q You say that in the context of having to explain why he might have to tell other people about it.

A I think I used the words that he had to take it seriously enough to tell other people. "Wrong" may not be the ideal word to use, but ...

Q We can check the transcript. Let me ask you it in this way. The fact is that he said that it sounded wrong to him.

A Yes.

Q On the afternoon of the 9th.

A Yes.

Q That was clearly confirming to the child that his view of what she had described was wrong, was it not?

A His view of what she described was wrong.

Q And that he was worried that he may have done it to other children as well. In other words, imparting his view that he was accepting what she had said as truthful, accurate, not misinterpreted, not misguided or anything of that sort. He was accepting it unequivocally.

A To her, yes. He may, in the back of his mind, still have a lot of caution about whether this was ... Again, we do not know exactly how she said it and what she did, so we do not know how it appeared to Dr Eastgate exactly at that time.

Q In other words, to this child, who was very keen not to attract his disapproval, who had been, I suggest, led on a previous occasion as to some detail, that she had done well. Is that not right? Is that now how she would have perceived that? What had happened was good.

A I do not see how you could say that.

Q Why not?

A Again, we do not have much information of this interview exactly and Dr Eastgate may have provided more under your cross-examination yesterday, but my view is that he did not say, "Well done for telling me", although that has been something that people have done when people have difficulty talking ---

Q I am not suggesting he said that but that is the impression this child would have derived from this, is it not?

A My impression would be, from what we have here and from what I read in the morning's evidence yesterday, that she told him her version of what had distressed

A her, that he listened to her, that she explained how she felt, as she had in other sessions, about feeling responsible for what happened to her and about things. She was surprised when he suggested that it sounded wrong because she did not know what doctors do, she was confused, and him taking it seriously enough to be worried about potential risk to other children, which is also possibly the surprise. It has been my clinical experience that when you raise the issue about risk to other children, it is always a surprise because these patients are so preoccupied with themselves and their own experience and feel themselves unique. They think they are the only ones that these bad things happen to. Then, it is a surprise to suddenly think, well ... I think that, as I say, it could be a question of judgment whether he said that then or subsequently, but having got his own conscious realisation that this was something that he had to take seriously, he conveyed that to the patient. I do not think he would be saying, "Good, well done." She did not feel that she had done well to tell him.

B

C Q Dr Hall, I think we understand what you are saying about that. What was the purpose in your view – can you glean any purpose – to him mentioning other children at all to the child?

A I think he was burdened by the issue, as I said earlier in my evidence, that he ought to be doing something and this is part of the problem of working openly with children. I do not do as much work with adolescents as Dr Eastgate does, but it is a question of different practitioners' practice. I probably would have thought about it and consulted before I risked saying to her that it was serious enough, that one had to think about other children and that is why he might have to do something. He was talking about confidentiality here because that is the anxiety and I do think there is a great pressure when you work on inpatient units and therapeutic work to say, "What we do talk about together is confidential but if there is something that concerns me enough, we have to take it outside the session." That is where I think he was burdened and I would say that, being burdened by it, he acted. Maybe you could argue that it was premature to have raised the issue of other children at that point.

D I think the other thing is that in therapeutic work with children, if a doctor takes something seriously like this and reflects back – I think it is serious; we have to be worried about other children – the normal inclination of a child would be to say, "Maybe I imagined it, maybe it was ..." and to retreat and retract, which is not what she did. So, I do not think ---

E

F Q Dr Hall, can we pause there. Two things. First of all, am I right in thinking that what you are suggesting is that there were extenuating circumstances here? That he was burdened by the shock? You said that the psychiatrist would be quite shocked to hear this.

A What she told him, yes.

G Q And you are suggesting that that is an extenuating circumstance for what is not an ideal form of interviewing and in fact we would suggest an inappropriate form of interviewing. Is that your evidence?

A No, I would not say it was inappropriate.

H MISS GLYNN: Are you saying that it is an extenuating circumstance? Let us take it in stages.

- A MR TAYLOR: Should it not be the other way round?
- MISS GLYNN: You have said that he was burdened and you have used that word on several occasions.
- A Yes.
- B Q Are you suggesting that that is an extenuating circumstance for what appears in this note?
- A If you take any practitioner's therapeutic work, we are all going to be told things by our patient which is disturbing to the patient. That is inevitable. I have had patients frequently whom one feels ---
- THE LEGAL ASSESSOR: I am not sure that examples, in giving answers, will be of much assistance to the Committee now.
- C A They are not being helpful?
- Q Probably because the Committee would be better assisted by having slightly shorter and more direct answers to the questions Miss Glynn is putting.
- A Yes.
- D MISS GLYNN: Can I try to break this down. You have given evidence that the psychiatrist would be shocked by what he heard.
- A Yes.
- Q That this would have been a burden to him, that he would have been burdened by it.
- A He would be burdened because he would have to think about what he should do and how she (sic) should react and try and keep the patient in mind at the same time.
- E Q Would you accept that this is exactly the sort of situation that consultant child and adolescent psychiatrists are trained and indeed used to dealing with?
- A No.
- F Q Why?
- A Because, as I was just about to say, there are many situations where we are disturbed by what our patients tell us and we have to handle it, but I think it is extra difficult if you are being told about the possibility of something that could be abusive by another professional. It is not common in our practice. It might be a child in a children's home talking about a member of staff ---
- G Q I do not want to go into other examples.
- A ... but I think it is harder to deal with those kinds of allegations than for any practitioner. It does not happen very often.
- Q That is exactly the reason why the professional should handle himself utterly professionally and not offload the burden or the shock onto the interviewee.
- A Yes, but you are talking about perfect people here.
- H Q No, I suggest ---

A A I think that the more difficult the situation is, if anything – and I do not know because I was not Dr Eastgate in that situation – he could have ... We do not know the quality of her distress and confusion about not knowing what doctors are supposed to do and feeling responsible for what happened. That was an important element of why he said it at that time. With the benefit of hindsight, as I have said, you could argue that you could have delayed saying it, but I do think that we do not act perfectly when we have to deal with something very tricky in therapy.

B Q I suggest that being told things that come up unexpectedly in therapy is the bread and butter of what a consultant adolescent psychiatrist does. They may be different things, they may be different degrees of shock that you may feel about it, but this is the bread and butter of the work that you are doing.

C A I think the nature of what happened here is not the bread and butter of what we do. We are of course told by children all kinds of distressing things and I think we also convey our reaction. Although, as I said earlier, the qualities of a good therapist is to be neutral, it is also to be warm and sympathetic. If a child is talking about a distressing experience, you convey concern on your face. If you are surprised by something, sometimes it is very difficult to conceal that you are surprised although again, on average, we try not to. I think this was more difficult and is not the bread and butter of practice.

D Q You say that one of the features that is important is that she went on to maintain her allegations over the next few days until referral was made.

A Yes.

E Q Do you not agree that if the consultant whose disapproval she is anxious not to attract has expressed that he is worried that this man may have done it to other children as well, it is very unlikely that she is going to retract? In fact, it is much more likely that she is going to go on to elaborate in the way that she did.

A Why would she?

Q She does not want to attract the disapproval of her clinical therapist, does she?

A You have brought that idea in.

Q No, Dr Eastgate did.

F A To a point, but it is not going to colour everything she says to him about attracting his approval or disapproval. I do not think that his relationship to her is so important that it overrides her ability to talk about difficult or not difficult things with him and I think a child that was trying to please a consultant, if that is what you are maintaining, would probably want to minimise it rather than to continue to maintain it. What would be her motivation? She was not an attention-seeking child from the impressions we have of her. Why would she want to have him pursuing for the sake of other children her allegations unless she felt deeply that they were true? I find it very difficult to understand that line of thinking.

G Q The fact is that you do not know what her relationship was with Dr Eastgate at the time, do you?

A No, but what one sees from this is a developing relationship of increasing trust – that is how I understand it – and openness, as you said earlier.

H

- A Q There is clearly a risk that she will take the view that she did not want to disappoint him.
A But he is not looking pleased. My guess is that when any practitioner in this position answering her queries about what doctors are supposed to do and conveying that it needed to be taken seriously in the words that he did would be talking about it seriously and concerned. They would not be saying, "Well done". It is not to please him.
- B Q I am not suggesting that they would be, but what happens thereafter is that she has sessions, two the next day on the 10th with him, so he is taking is sufficiently seriously to see her twice on the next day.
A Yes.
- C Q He sees her again on the 11th. It is quite clear that he is talking on the 10th in the morning about child protection procedures, so he is taking it seriously; is that right?
A Yes.
- D Q It would be very difficult for her in those circumstances to say, "Well, in fact I may have got it wrong, I may have misinterpreted it. It may not have been stroking my breasts, it may have been that I just felt uncomfortable because I was only nine and this was an embarrassing procedure."
A I think that would have been easier for her to do than to go on talking about something that was very difficult to talk about and was making her anxious. She must have been very anxious about what the repercussions would be of him taking it further and it would be much more likely that she ... I do not get the impression of this girl as a girl who could take control of her own life, so I agree that it might be hard for her to try and control Dr Eastgate, but I still think that a girl like this would be more inclined to minimise it rather than maximise it.
- E Q The fact is, you just do not know, do you, and there is a risk here.
A A risk?
- F Q A risk of her taking the view that she did not want to disappoint Dr Eastgate given the view that he had expressed to her about what she had said.
A Why would that be disappointing him?
- Q Is it true that we just do not know?
A We do not know, I accept.
- G Q Do you accept that by what, on your evidence, appears to be sub-optimal interviewing techniques at the very least although I challenge that, it is more than sub-optimal in our submission, he has run the risk that she will take that view?
A Of pleasing Dr Eastgate?
- Q Yes.
A That is the bit that I really find does not fit clinically with this case at all and does not fit with teenagers. Teenagers do not usually try to please the people they are working with. They might have a favourite member of staff from whom they seek more attention, but I do not get the impression that she would be saying this to please
- H

A Dr Eastgate and I do not think that Dr Eastgate conveyed that he was pleased to hear it. I would think it would be the opposite.

Q Do you accept Professor Zeitlin's evidence that only about 70 per cent of clearly allegations of sexual abuse are valid and that, of those that are not, 25 per cent are through misinterpretation and that that is what the studies show?

A I accept that finding but ...

B

Q Not through maliciousness or anything else of that sort but through misinterpretation of something that has happened to them.

A Yes and it would be easy to see at first glance when this girl made these allegations that that would be mine and probably Dr Eastgate's initial assumption, that she had misinterpreted what went on in the normal clinical examination as abusive, but she was not saying that it was abusive, she just said that it distressed her or she did not say that it distressed her but she indicated that it distressed her.

C

Q The fact was that Dr Eastgate conveyed the view that it was abusive by saying that he was worried that he may have done it to other children as well, did he not?

A But that was not just in relation to ... I think the misinterpretation ---

Q That it was wrong.

D

A That was when he talked about stroking breasts and things, which is ---

MR GLYNN: Sir, it may be that we do not need to go into this in further detail. It is likely, unless the Committee correct me, that the differing views are clearly identified under heads of charge 3 and 4. (to the witness) Could I move on to head of charge 5, please, Dr Hall, note-taking. One of the things you said to the Committee was that teenagers do not like to tell things over and over again.

E

A Yes.

Q Is that exactly why it is so important to take accurate notes of what they say the first time they say it?

A Yes, that is one reason.

F

Q Indeed, on 9 July, Dr Eastgate has explained why his note is fairly full there because it is clear that things are changing, developing and, to put it unemotionally, she seems to be saying something of significance.

A Yes.

Q Would you not agree that the note for the evening of afternoon of 9 July is wholly inadequate?

A Not wholly inadequate, it is inadequate.

G

Q Because it is an extremely important session.

A It is inadequate for the purposes here of understanding what happened at that time.

Q You have focused on the fact that Dr Eastgate would not have been concentrating on court proceedings or police investigations or anything of that sort.

H

A Yes.

A

Q He would have been concentrating on the treatment of this child. You would agree that, in order to reflect carefully after sessions and perhaps discuss with other professionals afterwards the treatment plan for the child, it would be very important to have an accurate note of exactly what was said and how.

B

A I agree it would be important to but what I suspect and what my understanding is that he had in his mind that week – it was unfolding as the week went on – is what had happened, which he conveyed verbally and discussed verbally with the people he needed to discuss it with. So, at that time, he probably did have an accurate recollection of how it, not word for word, but obviously, once you go away from the immediate situation, which is to discuss and talk with other people and get advice about how to handle it, that is when the importance and advantage of having detailed, accurate notes comes to the fore. There is no doubt that any of us, if we were in this position, would say, “I wish I had taken more detailed notes”, particularly of that interview of the afternoon of 9 July. Ideally, in professional practice, we should have done.

C

Q But this is not just counsel of perfection, is it?

A No.

D

Q It goes right to the heart of the job?

A No, it is not right to the heart of the job, I would contend. Right to the heart of the job is treating the patient, with the resources that you have available, to the best of your ability.

E

Q Let us look at the position when Dr Eastgate went on holiday on 19 July, which is only 10 days later. This was a child who was making allegations of, on the face of it, improper conduct by a very senior medical practitioner. It was clear, you may think, to Dr Eastgate that this was likely to blow up into something quite significant, would you not agree?

F

A If I was in Dr Eastgate’s position – and I think I have said this already in my evidence – I would recognise the significance of it and the need to take it seriously but I would also have – again, he is an experienced practitioner – a reality that it would only blow up into something significant if the girl was willing to make a statement to the police which confirmed what she had already told him. We are not talking about care proceedings here. The purpose of the note would be to assist the police and social services to understand how to take it seriously. My understanding is that that was conveyed verbally by Dr Eastgate. I agree that he should have written it down; it would have been helpful for everybody dealing with the case. But the issue of the case with the professor was not taken any further. The strategy meeting decided what they were going to do. I am not quite sure what would have happened if it had gone to the GMC, whether Dr Eastgate would then have been called as a witness, and, obviously, if he was, his notes of how she told it would have been helpful to the GMC. In terms of a police inquiry, the police would have had to have taken a statement from the girl and the other witnesses, and that would have been the important aspect. It would have been no different if a school teacher had said ---

G

H

Q Dr Hall, I think we understand what you are saying about this: he was not focused on GMC inquiries or police inquiries or anything of that sort. I am trying to ask you questions about the treatment aspect of this. Do you follow me?

A A Yes.

Q I am not suggesting that he was focused on the police at this stage. The fact was that he was about to go on holiday in 10 days' time. On the afternoon of the 9th he knew, because he had inserted a second session that day. He had only seen her a few hours before, at 1.15. Now he is seeing her later on that day. He knew that this was likely to be an important session, is that right?

B A He had seen it as important enough to see her again before that day was out. We do not know what it was in relation to at that time.

Q And he had seen it as important enough to make a fuller note of the earlier session.

A Yes.

C Q So he knew that something was happening?

A Yes, I do not know if he gave evidence as to when he made those notes, whether he made the note about the morning session straight after it and then went back and talked to her. The issue sometimes is: when can you make notes?

Q The Committee knows about that.

A I do not know about that.

D

Q Having accepted that he knew from the earlier session that something important was going to happen – and indeed it did; she made, on the face of it, a clear allegation of breast stroking on that occasion – can you think of any circumstances why you might not make a note for a further two days of that session?

A The circumstances have to do with – and only Dr Eastgate can answer that – the case load, timing, and when you are squeezing it in and when you are doing all the other things. He should have done, but, as I said, he may have given his priority to spending time with this patient, talking to nurses, and various other things. Only he can answer as to when he would have found the time to pick up a dictaphone after that session before the next session the next morning to do it. Ideally, he should have done. I do not think anybody, or even he, would agree that it would have done, but we do not know the circumstances.

E

F Q It is not just ideal; it is crucial, is it not? I suggest to you that it is much more than just ideal. He should have done it that night because once you have moved on to the following session you are not going to remember the detail?

A But sometimes it is physically impossible. Who knows what his commitments were that afternoon and that evening? It can be very difficult. To actually do a full account of it could take him --- I know when I dictate a very detailed session which I have just had it might take me half an hour.

G

Q But it would be important enough to spend half an hour, given this disclosure, would it not?

A We do not know what his other things were that were very important that time, including talking to the nurses. I am afraid I cannot tell you. Yes, I agree that it would have been helpful had he written it up, and it would have been good practice for him to have written it up, but only he can tell you why he did not. I am sure that he wishes that he had written up a full account of that session. I could also say that

H

A many of us fail to write a detailed account of sessions which were important in our everyday practice simply because you are about to sit down with a dictaphone and somebody calls you about a very important case and you are thrown off course and then you have to be at a meeting on time, or whatever it might be. I think the problem with child psychiatry is that we do not have a set clinic at this time of the day and an operating session at that time. We have very chaotic diaries. We are not well protected in terms of being able to get on quietly with things. We are always squeezing far more than we can into the day. I do not see that as an excuse. He should have written the session up, but only he can tell you what happened that day, if he can remember, which accounts for why he did not write that session. Clearly ---

Q I think you have made that point. Assuming that there was no specific timing issue that we know about, would you not agree that it was unacceptable not to have made a note that day?

C A I think that, if you had no timing issue, yes, you would sit down and do that.

Q To put the note-taking head of charge in context, can I look briefly at the period before 9 July? Would you agree that, if you had a patient who had, on the face of it, taken an overdose – too many pills of some sort, in this particular case too much amitriptyline – who had been admitted as an inpatient because of that alleged overdose on 13 June, if you, as the consultant psychiatrist in charge of her care saw her on 14 June, in other words the first session after that admission as an inpatient, having taken an overdose, you would make a note of that meeting?

D A I do not know what would have been the current practice with every case at that time in that unit or other adolescent units, I have to say. I think this case is somewhat unusual in that Dr Eastgate saw the girl privately and she then required admission, so he was more involved with her care than an ordinary consultant child psychiatrist would be. My feeling is that it would depend on the staff of the unit and who was there. Consultants can quite often only briefly see patients. That was not the case here because he already had an established relationship with her. I think that, if you are talking about the generality of it, often if there are junior doctors other people will make the notes on the consultant's behalf. That is all changed. With clinical governance and the much tighter record-keeping which has come into the health service, rightly so, since that time, consultants are writing. They still do not, actually, in my experience. They will do a ward round and it is the junior doctors who write what happens. They may talk to the patient. They often talk about quite important things, like giving them diagnoses, and things like that. The consultant does not usually write the note. I think that child psychiatrists are a bit unusual in terms of their role with patients. They have more personal relationships and less junior doctors. I would accept that ideally we would write notes whenever we see patients, but I would say that, if we looked at child psychiatrists' practice, very few would do that at that period of time, in 1996.

G Q You are suggesting, as I understand it, that there may be good reasons for this but you just cannot tell what they are?

A Good reasons for?

H Q For not taking a note in those circumstances. If we can assume that there were no resource or timing issues specifically relevant to failure to take a note, presumably

A you would accept that it is unprofessional not to have taken a note of the very first session after a child is admitted as an inpatient?

A Can I clarify this? I am being asked about something which I have not closely looked at. She was admitted to the paediatric ward when she first came in.

Q Yes, on the 13th.

A The notes would have been in the paediatric record.

B

Q Dr Eastgate saw her on the 14th, the 15th and the 17th, but the first note we have is on 18 June.

A Can I clarify whether that includes also the paediatric notes? In my practice, when I have a patient, even if I know them already, who is admitted to a paediatric ward, my writing would go into the paediatric records rather than the psychiatric records.

C

Q That has not been suggested by Dr Eastgate. If I could ask you to turn to tab 2, page 4, you will see specifically what we are referring to: session 18 June 1996. The previous note is dated 12 June, on the previous page. Do you see that?

A Yes.

D

Q Then there is reference to:

“I have seen [Miss A] individually on 14th 15th 17th and 18th June 1996.”

But there is no note in relation to the 14th, 15th or 17th.

A I do not know how Dr Eastgate was working at that time or how other child psychiatrists would practise at that time, but this is a file note for his psychiatric notes, as I understand it, and I would certainly not write in my psychiatric notes every time I see a patient in another setting; I would concentrate on writing, if I was writing, or making sure there was a note if I was telling somebody else and they were writing, as would have been the common practice at that time. It would possibly be the paediatric SHO who would write in the notes there. He has summarised what has happened since the admission for his own use, as I understand it, not as a medical record.

E

F

MISS GLYNN: Perhaps I can conclude that part of the questioning by informing you that Dr Eastgate has not said that that is what happened. Assuming that that did not happen, you would find that unusual, would you not?

THE LEGAL ASSESSOR: Miss Glynn, I think that one member of the Committee and I myself are slightly troubled by the thought that actually there was some evidence from Dr Eastgate to the effect that there may have been some reference on the paediatric records rather than in the psychiatric records. Mr Turner may be able to help us.

G

MR TURNER: Yes, sir, there certainly was. It came up when he was giving evidence about the note that followed immediately after the admission. It is page 4 of tab 2. He was asked about the absence of any notes for the 14th, 15th, 16th, 17th and 18th June.

H

A THE LEGAL ASSESSOR: Can you pin that down a bit, Mr Turner, by about what time of day it was, perhaps, or by reference to other questions we might find in our notes?

THE CHAIRMAN: Do we have the transcript?

MR TURNER: We have just received the transcript.

B

THE CHAIRMAN: Could we find it in the transcript?

MISS GLYNN: Sir, to save time, I am quite happy to make that concession.

THE LEGAL ASSESSOR: Now we have raised it, I think perhaps we should see if we can find that passage in the transcript and have a quick look at.

C

MISS GLYNN: Certainly.

MR TURNER: It is page 82, starting halfway through letter D and continuing.

THE LEGAL ASSESSOR: The passage that I seem to recall, and which members of the Committee also recall, is on that page from F/G down to H, is it not?

D

MISS GLYNN: Yes.

MISS GLYNN: What Dr Eastgate is saying, so that you are clear, Dr Hall, is:

E

“At that stage she was a paediatric patient and my normal practice would have been to have made some note in the paediatric file. I have not looked at that file in the context of this case, but I would expect – although I cannot promise you – that if you ask the paediatric department of the former Princess Margaret Hospital for Miss A’s medical file, you will find some brief written comment from me that I have seen her. As I said, I do not have the file here and I have not looked at it in the course of these proceedings.”

F

He is saying that there may be a brief note. It is clear, Dr Hall, if you turn to tab 3 of C1, which is the nursing records, and look at the top entry on page 1, that Miss A was residing as a patient on Hannington.

A Yes.

G

Q That is on 17 June. That is one of the nurses working with Dr Eastgate. But there is no note of his session with her on 17 June. I do not want to spend too much time on this, but, given the circumstances, would you expect there to be full notes of these sessions?

A These are nursing notes, are they not?

Q Those are nursing notes. What that shows is that she was on Hannington by the 17th.

H

A Dealing with emergency work, and we have to supervise and train SPRs nowadays, the issue is, with medical notes, what you write in terms of details in medical notes. My practice, and which I teach SPRs and which is common practice

A really, is not to write lengthy handwritten notes in the medical notes about personal details about psychiatric issues but to give the gist of how the patient is and management issues and to acknowledge that you have seen the patient. I do not think it would be normal practice for him to write a detailed account. The purpose of having a detailed account is to assist him in his therapeutic work and those of the psychiatric unit, so it is actually holding in his mind the issues that are important for the patients. That is the purpose of the medical notes.

B

Q But there is no note at all on the 17th. Once she is out of the paediatric ward and she is on Hannington, there is no note at all on the 17th.

A Is this the medical notes of the psychiatric unit? I am sorry, I am confused now.

C

Q She is an inpatient under Dr Eastgate's care, not in a paediatric ward but in Hannington.

MR TURNER: I think it is Hannington where she was admitted to.

MISS GLYNN: It may be that there has been a misunderstanding, then.

D

THE LEGAL ASSESSOR: My own impression – and it looks as if some of the Committee agree – is that Hannington is where she went.

MISS GLYNN: I am sorry if I have got that wrong.

Q Can I ask you to look in tab 2, which is the tab with the file notes in it, and look at page 2? There is a note there which is headed "End of May 1996". Is that something that causes you any surprise?

E

A I read about Dr Eastgate's view about this in the transcript yesterday. I think he obviously dictated this after the event – that is probably the likelihood. If he did write "End of May" it would imply that he did not look in his diary to confirm which day that session was. The explanation for that would lie with him, that he had not made a note of it in his diary, or something like that. I do not understand why he would have written that. He could have easily written a date there and possibly he could not be accurate about which date it was, for whatever reason that would be.

F

I do not understand. I agree it looks sloppy. He is talking about one session. Why he would write "End of May" --- The suggestion would be that he wrote it after that date.

Q Would you agree that the adjective "sloppy" is equally appropriate if one turns to page 8, on the assumption that all the notes there, including the note for the extremely important session of the afternoon of 9 July, were made on the 11th in that very brief form? Would you agree that "sloppy" is the correct adjective for it?

G

A I would not call them sloppy here. He has obviously dictated them all together and he has obviously found time to sit down and describe what he felt were the key issues in those sessions. As to the issue as to why did he not write a more detailed note at the time, only he can answer that. It obviously is inadequate. As far as the other sessions, he has obviously noted important details about those sessions but not an adequate amount of detail.

H

A

Q If one turns to the note of 16 July, which you will find at page 10, you will see there Dr Eastgate making a note on that day, towards the bottom of the page, after the strategy meeting:

B

“...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 illicit information. Thus it is quite reasonable to ask her what she can recall, to be supportive and encouraging as she tries to talk, but not to make suggestions as to what might or might not have happened.”

C

Dr Eastgate has given evidence that that was nothing new to him the time. This did not take him by surprise. He knew about this. In the light of that, would you agree that that note taking revealed on page 8 is sloppy?

A You use the word “sloppy”. I would say inadequate, but ---

MISS GLYNN: But when we look at 19 July, bearing in mind ---

THE LEGAL ASSESSOR: Miss Glynn, she did say “but”.

D

THE WITNESS: I suppose there is a slight difference between those notes that were taken before the strategy meeting – and I agree they should have been more detailed – but at the strategy meeting there was a clear decision on the part of the police that they were going, if the girl agreed, to investigate it, so it was important, and it should have been important before, I agree, that there were notes taken about anything that she did say.

E

MISS GLYNN: Looking at what happened after the strategy meeting and after that note was taken by Dr Eastgate, there is a letter dated 19 July at tab 1, page 24. Dr Eastgate has given evidence that this relates to a session he had with Miss A on that day, and it is the only note that exists of that session.

A Yes.

F

Q And all that has gone before?

A Yes.

Q You will see in the second paragraph:

G

“...Miss A told me this process of her going to see Professor X started when her parents looked at her and said ‘.... you are getting too big at the age of eight, you need to see someone to stop you growing’. This left Miss A feeling quite hurt, partly because Miss A says her father also felt her at the same time and she found this humiliating and degrading.

“I do not think this is yet a Child Protection issues and... is certainly keen that it is kept very confidential.”

H

A Given what Dr Eastgate has said on 16th about the requirement for verbatim notes, what do you say about this? Sloppy must be an accurate description of it, must it not, at the very least?

A Well, obviously he should have written a more detailed account of this but he made a note of the important issues and his interpretation, which is how it left Miss A feeling quite hurt, so that was a bit of his clinical observation mixed with what Miss A says, and what she said at the time, so he has included the key points here for the

B nursing staff to know before he went on leave. Now, the question is the fact that he did it in the form of a letter rather than in the form of note-keeping but it was for the medical notes, so I think there is, as I said earlier, an issue about a practitioner's individual practice, about how much you write notes for the sake of the notes and how much you write notes to communicate. Very often, child psychiatrists I would say more than other professionals in child mental health practice, try to combine writing letters to inform people with what is in the notes. If you had just written in the notes,

C you would have to say, "You have got to look at my note there", whereas he actually was drawing it to the attention of Mel Smith, so that she knew she had something important to deal with before he went.

Q Of course, you said that he included the key points. If he had been told by Miss A that she had been touched intimately by her father and her father had touched her breasts, those would have been key points, would they not?

D A They are key points.

Q They are not there, are they?

A No, they are not. They should have been.

Q And this was the day when Dr Eastgate was going away on holiday, leaving her care in the hands of others who were not present during the consultation?

E A Yes.

Q Do you understand that?

A Yes.

Q This was extremely sloppy note taking, was it not?

F A We do not know what he said to the nursing staff and what he did. Again, my criticism of child mental health practice historically has been that child mental health practitioners, and I am not talking about psychiatrists necessarily but all of them, have done far more by talking and telling people than writing things down. It has been a slow evolution really of child psychiatric practice to write more and more. Of course, this has put much more pressure on practitioners because we have to do both. We have to speak to people and things, the same as in any other branch of the profession. If you have a big anxiety about the patient, and you are going on holiday, supposing

G you are the consultant, you would want to tell your junior staff or the nursing staff that this was what was very important, whatever it was, but you might and should also write it down in the notes. But, I have to say, in many areas of practice people do one or the other, and this is obviously something that has happened here.

Q You are not suggesting you would have written a note like this in these circumstances where you have got a child who has made an allegation against a

H

- A paediatrics professor and who now seems to be saying something about her father?
You are not suggesting you would think it appropriate to write a note like that?
- A I am saying he should have written down there what the girl said her father had done word for word there. I agree.
- Q By this time, it was absolutely clear in 1996 that proper records should be kept of all such consultations, is it not?
- B A Yes.
- Q Let us look at *Working Together*, tab 4.
- A Yes, I agree that he should have written it down.
- Q Can I move on, briefly I hope, to head of charge 6, which is the referral head? You would agree, would you not, that verification is not the same as investigation?
- C A I do not actually like the word “verify” because “verify” from its derivation means finding out the truth, and that is not actually the job of the practitioner. I disagree with that.
- Q Let me not waste time on semantics. Perhaps it is my fault. The fact is that nobody is suggesting that Dr Eastgate should have investigated this matter.
- A No.
- D Q What is being suggested is that he made the referral, or the report, whatever you care to call it, on 12 July prematurely without having arrived at the required level of suspicion. Do you follow me?
- A Yes.
- Q Would you accept that the guidance at the time was clear that you do not refer in every case in which you have a suspicion of child abuse. There is no requirement to refer in every case in which you have a suspicion of child abuse.
- E A There is no statutory requirement.
- Q There is no common sense requirement, is there? Vulval vaginitis is the example that was given by Professor Zeitlin.
- A If you are not suspecting child abuse, I mean vaginitis is a common finding, but if you had vaginitis plus something else, then it is different. It is the level of suspicion that is important. You cannot refer when a suspicion is not strong enough.
- F Q So the guidance, taken as a whole, would indicate that where you have a suspicion you refer when it is based on a sound clinical judgment that can be justified later on. Would that be right?
- A I do not know about sound clinical judgment. If a child tells you something that sounds like abuse and, in exploring with it, you yourself expect that is, yes, there is sound clinical judgement in the sense that you are taking the non-verbal language of the child at the time, in context and everything, and that you would be much more cautious if it was a difficult divorce case going on or something like that. So, yes, I suppose in that context it is sound on the basis of the information that you have; then it is based on sound clinical judgment. But you are not deciding whether abuse has occurred. That would be dangerous. You are just having a suspicion.
- G H

A Q Of course not and it is not being put to you that you are. Could I ask you to turn to the Cleveland Report, please, D5. (Same handed to witness) At page 248, paragraph 8(iv), reads:

“ practical issues need to be recognised and resolved at local level in careful discussion between the respective agencies. For example:

- B
- what the level of suspicion of physical or sexual abuse should be before the Police are informed than an offence appears to have been committed;
 - when and what parents are told when doctors see signs that may be indicative of sexual abuse...”

C From that we can see that there were to be local guidelines established. Is that right?

A Yes.

Q Following what had been decided at Cleveland?

A Yes, and that is what happened. *Working Together* came in at that time.

Q Yes. Turn several pages over, please, to page 251 (vi):

D

“If there is a suspicion of child sexual because in the mind of the professional”

– as of course there was in this case, Dr Hill, I suggest –

“the danger of false identification ought not to be forgotten. Therefore when a suspicion arises the professional may elect to:

E

- take no further action;
- hold a watching brief;
- make further informal inquire.....

“The level of concern may reach a point within the guidance agreed with other agencies.... where it is the duty of all professionals to inform others or refer to the Specialist Assessment Team.”

F

A Yes.

Q There we are looking at whether or not the level of concern has reached a point when it should be referred?

A Yes.

G

Q As agreed with the child protection team, or whatever guidance?

A Sorry, the level -----

Q We can see, “as agreed with other agencies where it is the duty of all professionals to inform”

A But there is not an agreed level. That is the problem. That is a matter of clinical judgment.

H

- A Q Exactly. If we turn to the Wiltshire guidelines, which you will find in the literature bundle at tab 7, the section that deals with health professionals ---
A It is the Department of Health guidance. Is it in here?
- Q It is in there at section 5. This is the guidance which evolved as a result of passages we have just been looking at, the local guidelines. Paragraph 5.1.8:
- B “General Medical Council ... 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.”
- Pausing there, the word used there is “belief”.
- A And that is where we have disagreed all along, is it not, in the use of the word “belief”?
- C Q Yes.
- “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.”
- D A Yes.
- Q The key words there, do you agree, are “sound clinical evaluation and judgement”?
- E A Yes.
- Q If we turn to the addendum of *Working Together*, page 3, headed Part 2 at the top,
- “Preliminary consultation, strategy discussion and investigation”
- F A Yes.
- Q Paragraph 2.5:
- “Where uncertainty exists doctors will often find it helpful to test out professional hypotheses before initial concerns about child abuse are shared with non-medical colleagues.”
- G A Yes.
- Q “Doctors should clarify their own thoughts about a particular case, and with advice as appropriate from senior or more experienced colleagues, reach a critical threshold of professional concern.”
- A Yes.
- H Q

A “When a critical threshold of professional concern is reached doctors must be prepared to share these concerns with the statutory agencies for further evaluation and discussion within a time frame which is not detrimental to the child’s interests.”

So we have clinical evaluation and judgement and we have critical threshold?

A Yes.

B

Q Those are key phrases, would you agree in the consideration of this part of the case?

A Yes.

Q In this particular case, Dr Eastgate was dealing with a very disturbed, unhappy child who did not like Professor X? That is right, is it not?

C

A Yes.

Q And indeed, she did not like other doctors, including a female doctor, Dr Janet Treasure, so it was not unique to male doctors. He knew that Professor X had been undertaking Tanner Staging?

A Yes, or he would have presumed he had. I do not know that he had seen any clinical correspondence on this.

D

Q Just the sort of procedure that may be open to misinterpretation by a girl in these circumstances. He knew, because he has given evidence, that she did not want to incur his disapproval.

A Again, you keep saying that as if it is a very, very important thing.

Q You have given evidence about that.

E

A I mean, it may have been part of her relationship with him, but I do not think that would be the primary, overriding issue for her.

Q And you agree that 25 per cent of clear allegations are made through misinterpretation and are not in fact valid?

A Yes.

F

Q You agree that there was no immediate danger to Miss A at the hands of this alleged perpetrator?

A Yes.

Q Could I ask you to turn to the file note, tab 2, page 10, please. This is 16th, and can you see in the bottom paragraph that on 16th Dr Eastgate was suggesting to Miss A that it was important that she did try to be rather more clear about why she felt so uncomfortable with Professor X.. Do you see that?

G

A Yes.

Q In all those circumstances, Dr Hall, is it not clear that before the critical threshold as reached, it would have been appropriate to contact the parents, the mother having been there during the sessions, to find out what the parents have to say?

H

A I think that would be the least appropriate decision to have made.

A

Q Why?

A Because, if you put yourself in the position of a practitioner, and I for example have not worked as a paediatrician, I did not think, and I was asked that opinion originally by the GMC about what I thought about the behaviour of Professor X in relation to Tanner Staging, that Tanner Staging involved touching, but what I did was I looked in my medical textbooks and spoke to paediatric colleagues to be absolutely sure. I cannot recall whether many child psychiatrists have done some paediatrics and I cannot recall whether Dr Eastgate has. If you have done paediatrics you might be in a different position because you would know what Tanner Staging involved. So there is that aspect. If you are not sure, I certainly would have waited, because I come from the position of more uncertainty than somebody who has done paediatrics – I do not know what the position was – but the last thing you would do would be to talk to the parents. If a girl is saying something that you are worried about, whether it is to do with sexual abuse or not to do with sexual abuse in a clinical interview – it may be a horrible incident at school, or whatever it might be, which is very distressing to her – you would not want to jeopardise her relationship with you, particularly, as I said, in other circumstances if you had child protection concerns, by talking to parents, who might react in different ways. This girl, as we know, did not have at that stage a very close relationship with her parents. She was in an inpatient unit, her parents were going backwards and forwards from London to S, as I understand it. I do not know what kind of involvement she actually had directly with them at the time. You want to keep her parents informed about her clinical condition, but when you are talking about difficult issues, whether it is to do with sexual abuse or not, you have to have quite a lot of thought about when it is appropriate to discuss it with the parents. That is the start. If it is a concern about sexual abuse, and this was the case here, you have to think very, very carefully if there is an issue around a professional, whether it is a doctor or a children's home worker, about going to parents because of their reaction and the impact that will have on the child. We have talked about doctors having to stay cool, calm and collected in the face of hearing troubling things from difficult teenagers, but a parent could react in all different ways. My contention is that as a parent, I would be upset if my daughter was distressed. There might be one part of me that would want to minimise it and think, "Well it is just the Tanner Staging, she is over-sensitive" or you might feel angry with somebody – the mother had already said she felt this doctor was insensitive – if you had learned that your daughter was very, very upset by what had gone on in the consultation, you might feel guilty too for taking the child. The parent's reaction is more likely to be emotive than anybody else's because, after all, they care about their child and they are puzzled and confused and worried, I would contend, when they hear that there is an issue. So my view would be that the absolute proper thing, particularly when there is public importance attached to the risks to other children, is that you seek professional advice before you speak to parents. We are not talking about abuse within the family here – and that would also apply there – in this case it would be very damaging to this girl if the parents – in ideal circumstances, an ideal parent would be sensitive to the girl's concerns and want to understand why she was so upset – but, as we learn now with the benefit of hindsight, the parents were very concerned and said it could not possibly have happened and did not want the police to be involved. So they did react strongly. I think I would be very cautious about it. The other issue is the investigation side. Anything – and we were taught this very, very clearly after Cleveland. If there is a question of criminal or, in this case, professional misconduct,

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A either/or, that you do not go in and contaminate it by trying to get the evidence yourself. You wait and, if a decision is made that it is going to be properly investigated by the police, it is their job, and that is what they advised here. The mother was given the courtesy and, through her, the father, of knowing what was happening and that there was going to be a strategy meeting, but it was very important in my view and I would advise any professional, experienced or otherwise, to seek advice before they talked to anybody. I was quite shocked yesterday to hear Professor
B Zeitlin suggest that he had talked to doctors when there have been concerns of this kind. The last person in any suspicion of sexual abuse you talk to is the person who is accused. That is the job of the investigators.

Q Can I go back, please? You have said that one of the reasons you would not contact the parents is because of their reaction.

A Yes.

C

Q The parents are going to have to be told at some stage, are they not?

A Yes.

Q Indeed, the parents were told on the 12th, shortly after the referral had been made, in the presence of the girl herself.

A Yes.

D

Q Can you see any reason why the parents should not have been told at some stage before the referral was made?

A I think I have just said why.

Q Because of the reaction of the parents?

A That was one of the reasons.

E

Q What difference is there between, say, the evening of the 9th, 10th or 11th, and after the referral has been made on the 12th?

A Because I would want to get professional advice. If the parents reacted strongly and said, "Dismiss this girl's concerns", you would be very easily in a very difficult position. Either it would alienate her from her parents, which is I think what I understand happened. She became angry with her parents when they did not take it seriously – or she would feel her feelings were not validated and that she was overreacting or something like that, which also would make her feel that she was not being taken seriously. Of course if they acted with great concern, they might also influence her already before a decision has been made about whether this should be investigated or not. I think it is terribly important to seek advice before – I cannot see any harm in seeking advice before talking with parents. That is putting it the other way round.

G

Q Were you surprised – maybe you do not know this – that Mr Evans said that there was no question after he had been told about these matters involving an eminent paediatrician of not referring it; he would have referred it whatever Dr Eastgate had said or advised.

A Yes, but he ---

H

- A Q Once the contact was made with Mr Evans, there was no going back. There was going to be a referral, was there not?
- A Yes, but a referral means they are going to look at it. It does not mean that action is going to be taken. As it happened, it was not. It was considered and thought seriously by the child protection services. As I said earlier in my evidence, my view would be that at the strategy meeting or subsequently, if the girl had said, "Look, I don't want to give a statement. I don't want any more to do with this", which is essentially what did happen, then they could not have acted upon it. But the issue still has to be that they have to make inquiries. It is the same with a children's home or any area where there might be sexual abuse. Once someone has made an allegation, there have to be inquiries, because if there were other complaints – supposing it was found that other complaints had been made about this Professor – then it would be very important that this was taken seriously.
- B
- C Q It would make no difference whatsoever whether the parents had been told about it before the referral was made, would it?
- A I think it would have done. It would have coloured it. We do not know what the validity of the allegations that the girl made was, but it would be very important to look at them coldly and objectively. Parents get very anxious, anybody who is working with sexual abuse. Even more so when there is a stranger involved. The reverse is to deny that it could possibly have happened. So you need to be able to get advice first.
- D
- Q Would you agree that the spirit of all the guidance at the time was that the parents should be involved at all stages? A clear, unequivocal mandate, according to Professor Zeitlin, to consult and take the parents you at every step, unless there are good reasons not to.
- A Yes. If there are good reasons not to.
- E
- Q In this case can I ask you some specific questions. It is clear that ---
- A Sorry, could I just say that most of that guidance about involving parents, if you look carefully at the documents, applies to not at the initial referral stage, but in terms of working with parents around child protection investigations, child protection procedures, care proceedings, all of those things. I think the importance – and I think we certainly learnt that very clearly in the 1980s and going on into the 1990s, that getting professional advice is very, very important. I do not think anybody would be suggesting that it would be inappropriate in most cases of sexual abuse to inform the parents before you have professional advice. Whether it is injury to a child that you are not sure about or whatever, you get advice. You do not speak to parents until you have actually decided whether or not you are going to take this seriously.
- F
- Q Considering the critical threshold point, if I may, can you see any objection to contacting Mrs A and asking her some questions about what happened during the consultations with Professor X, without making any reference to sexual abuse or stroking her breasts whatsoever?
- G
- A I think the issue would be – and again, nobody has really discussed this in this hearing and I am not sure what the child said – but, for example, if you were dealing with a child where you have gone to a consultation with a doctor, the child might say, "Well, you ask my Mum." So the girl would be giving permission. I think if you were going to then speak to the mother, you would have to do it with the girl's
- H

A consent. My contention is that the job of verifying whether or not – if you get to the stage where you are going to investigate abuse, the importance that the police have first-hand information of an allegation as serious as this – and this is a serious allegation, even if it is not clear whether there is abuse behind it or not. I am not saying whether it was abuse or was not abuse, but the allegation was serious.

B Q What is your professional opinion about the appropriateness and professionalism of Dr Eastgate saying in front of the child to the mother that he was 98 per cent certain that it was criminal on the 12th?

A That was what the mother had said. I have read the transcript from yesterday morning, so I am not sure what was actually said.

Q if it was said, what is your professional opinion?

C A If it was said. Again, what are we referring to? That the girl said Professor X stroked her breasts and touched her in other intimate places. Is that the assumption of what that is linked to? I am not sure.

Q He said, with the child sitting on the floor in the same room, that he was 98 per cent certain it was criminal.

D A Again, it is very hard to look at it with hindsight. The implication could be interpreted in different ways. You could be saying that if what the girl said was true and it was verified, then it was 98 per cent clear it was criminal, assuming we know exactly what the girl had told him, or he could be saying that – implying – I am sorry. The girl has made some allegations. Either these are an exaggeration of her reaction to a clinical examination which was perfectly normal and proper or the examination was improper. If a paediatrician is acting improperly towards a child, then that would be criminal. So it is hard to know exactly what he was interpreting from it. But if he was asked, if any of us were asked, if a paediatrician was getting gratification from stroking a child's breasts and touching intimate parts as part of their professional practice, then that would be criminal, just as it would be ----

Q I am asking you not about the value judgment about what the allegation amounts to. I am asking you about the professionalism or otherwise of saying that in front of Miss A to her mother.

F A I think it would be difficult. I do not know how the question arose, whether she asked whether it would be a criminal offence or how it arose, but it is very difficult to judge it without knowing the context of the interview. But I agree on the face of it, it does not sound very appropriate to say, but he may have had great difficulty convincing the mother that there were serious concerns and it may be that is why he said it so strongly, or it may have come as an answer to a question. But I agree, on the face of it, it does not sound like the sort of thing one would choose to say.

G Q If you had a patient who was cutting her breasts under your care, would that be something you would want to tell the parents about?

A I think it is normal practice for parents to be informed of any kind of self-harm on units. It would depend on when you see the parents and how much – because children who self-harm can be scratching themselves every day – it has become quite an epidemic now ---

H

- A Q If I can take it shortly. In principle, you would expect the parents to be told. Is that right?
- A Yes. But if it was just part of her cutting – I think if a girl is cutting herself, you would want her parents to know.
- Q If she had taken 20 microgynon tablets, would you expect the parents to know about that?
- B A I was puzzled by that. I think it depends. If you have a sexually active girl that the parents are not aware of their sexual activity, you might want to say they had taken an overdose. It depends on the thing. We have actually kept that kind of information from parents, simply because of ethical issues around ---
- Q That is not the situation here, is it? She was 13, she was not sexually active, she was taking these hormones for reasons of her treatment.
- C A I do not know whether she was still taking hormones. That is one of the things that puzzled me, why she was taking them.
- Q I am sorry. That may be an unfair question. If I may move on very rapidly, please, to the potential consequence of making this referral without taking the parents with you step by step. Do you agree that there is, as well as the risks you have set out, also the risk of creating a division between the parents and the child by not telling the parents what is going on as it is happening and before the referral is made?
- D A I think it can go either way, that is the trouble, and until you have told the parents you do not know which way it is going to go. It could alienate the girl more from her parents, as appeared to happen in this case, that she was upset because they did not take her seriously, or it could go the other way round and, with a very good response, the girl could feel very supported in having her concerns taken seriously.
- E Q Dr Hall, it was not a question of the concerns not being taken seriously, was it? It was, from a reading of the papers, that the mother had been present and had not seen anything happen. The parents were very concerned about the consequences of the police becoming involved in circumstances such as these.
- A I think again in an ideal world, with ideal patients and parents, what you would hope is, if a girl raises serious concerns about how she felt during a medical examination at which the parent was present, you would hope that if that was agreed with the girl that would be discussed with her parents, the parents would want to understand why she was so concerned. It has another dimension to it if it is something that might be professional misconduct and the risk to other children, because that then comes into and that did in this case because a decision was made to talk to the police. So obviously you are then dealing with the parents' anxieties about the police being involved, which is understandable, especially for parents who have never had any experience of – most parents have not had experience of - child protection procedures. So you can understand parents being alarmed and anxious and that would detract from them being able to quietly hear the concerns of the girl. If you had a different situation where you had a mother and daughter in an outpatient setting, when the girl revealed these things in the mother's presence and the mother was concerned as to why she should feel upset by it, then you could have a very good reaction and it may or may not be because of any improper conduct. But this was an unknown quantity. So I think there was a risk to the work and the child's relationship
- H

A with her parents of talking about it prematurely before you decided what you had to do.

Q You have said several times that your understanding was that the parents would not take this matter seriously.

A No. I was saying that was a risk that could happen.

B Q You have given evidence even about the notes in this case that I suggest to you are providing excuses and reasons for Dr Eastgate's failures, as we would put them, I suggest providing evidence of, if you like, an apology for Dr Eastgate on almost every count. Do you accept that you have provided reasons of excuse and so on, reasons why he has acted as he has in relation to every single head of charge here?

C A I would not say it was an apology. I think it is an understanding of his position. I do not excuse the fact that he did not give a detailed account of particularly the afternoon of the 9th, an I am sure he would not. The issue is that he did not. In terms of understanding why he did not, only somebody who could see what he was doing in his practice, his other patients and his other work, would be able to explain that.

THE CHAIRMAN: If I may say so, I think we are in danger of going over the same issues.

D MISS GLYNN: I am asking you about your understanding of your role as an expert witness. Your role as an expert witness was to be wholly objective, is it not? Yes?

A Yes.

Q And to analyse the evidence before you in an objective fashion, without making any value judgments of any of the parties involved in the case.

E A I think ---

Q Do you agree with that or not?

F A I think so. That is the aim, but one cannot always be entirely objective in any case that one looks at, because one is bound to be coloured by experience – and that is why we are experts, because we have a lot of experience – so for example, I would say that dealing with these kinds of cases is one of the most difficult kinds of cases that there is. So I am coming in with a subjective opinion that these are difficult cases and therefore I am not judging it as if one can look at it coldly and clinically.

Q You have a subjective opinion about the parents in this case, do you not? I would like you to look at paragraph 7 of your report, please. The second sentence,

G “It is not clear why Mr and Mrs A have chosen to pursue their concerns about Dr Eastgate's professional practice in relation to his handling of the allegations their daughter made about Professor X and Dr Eastgate. Most parents would be keen for their child's views to be taken seriously and investigated properly.”

A Yes.

H

A Q In other words, you are suggesting that perhaps in this case they were not keen for their child's views to be taken seriously and investigated properly; is that the view you took?

A Yes.

B Q If you look at the *Working Together* document, paragraph 5.14.10 at page 30, there is reference to what is perhaps common sense, "The process of investigation is painful and difficult for those who undergo it" and then there is reference to the situation where a child is the subject of unsubstantiated allegations, in other words she has made allegations that are not later substantiated, and the effect it may have on her.

A Yes.

Q Those are references to very serious adverse consequences there may be of an investigation where there is very little prospect of a conviction.

C A But that is talking about ...

Q Mrs A was present during the consultations with Professor X, was she not?

D A "The process of investigation is painful and difficult for those who undergo it". That is presumably talking about caretakers who are being investigated. It is obviously difficult for anybody involved in a child protection investigation. It is obviously difficult for the child, it is difficult for the person who is under investigation and it is difficult for those caring for the child in terms of supporting them. Obviously you have to decide – and that is the purpose of the strategy meeting – how far you go with your investigation.

Q You have taken a value judgment, a subjective judgment here, about the parents, have you not, with respect to the attitude they adopted when they found out that the referral had been made?

E A All I am reflecting is that I am puzzled by that.

Q Why were you puzzled?

A By their reaction.

Q They, as parents of this child, had to look at the long-term welfare of their daughter, did they not?

F A Yes, but my understanding from the evidence we heard initially ... I have never met the parents but I have had wider access to information about this case than the issues that are before us here because I was initially asked to prepare the report for the GMC, so I do know a little more about the case but I have not looked at that part recently, I have only looked at these charges in relation to this hearing, so my attitude might be coloured by the totality of the case ---

G THE CHAIRMAN: It is very important that we do not hear anything that refers to anything that we do not know about.

A I am sorry, but I was just being asked about my judgment and opinion and I am having to be very honest here.

THE CHAIRMAN: I am asking Miss Glynn to tread carefully.

H

A THE WITNESS: I could be influenced, as Professor Zeitlin was asked about being influenced having met the parents. As I have said, I approached this case having never met anybody involved with the case. As regards the issue of my judgment of the parent's attitude – and I apologise if I sound judgmental – is that what I did hear in the first part of the hearing was that the parents did not want an investigation for exactly the reasons that are listed here, that it would be protracted. What I find puzzling now, unless it was driven by the girl's desire to sort out these problems, is why this is being pursued in relation to allegations against Professor X that were never pursued given that the parents were not concerned about pursuing the initial allegations. That is what I am referring to here, not judging. So, I am sorry ---

MISS GLYNN: That may be an issue for the Committee when they consider seriousness in due course.

A Yes.

MISS GLYNN: Thank you, Dr Hall.

Re-examined by MR TURNER

Q Dr Hall, please take the *Working Together* document. You were looking at page 30 a moment ago and you were asked to look at paragraph 5.14.10. It is unfortunate that the subheadings do not seem to have photocopied very well, but let me tell you that paragraph 5.14.10 in the original has a subheading that reads, "Where no substance is revealed to the cause for concern". The paragraph above that, paragraph 5.14.9, has the subheading, "Recording of interview" and, if we put it fully in context, on the previous page, paragraph 5.14.6 was headed, "Selection of staff for interview." So, bearing in mind that this is a chronological approach to the procedure that should be followed, what stage is being spoken about in the guidance by the time one is getting to the selection of staff for interview?

A A formal investigation.

Q Following a strategy meeting?

A Yes.

Q So, by the time we get to page 30 and paragraph 5.14.10, there is clearly reference there to an investigation, it is a process of an investigation.

A Yes, but it has to be accepted that if you make a referral or draw a problem to the attention of social services, it could lead to a formal investigation, so you still have to think about the various individuals in the process and the purpose of it.

Q You have accepted in answer to Miss Glynn's very early questioning that, certainly at the stage we are speaking about in this hearing, up to 19 July, this was not an unusual case for an inpatient case because they all concern children who have severe difficulties otherwise they would not be inpatients.

A Yes.

Q It may not have been an unusual case but was it a difficult case?

A I would say that it was difficult but then many of the children who are inpatients are very difficult.

A Q You were asked a lot of questions about the second session on 9 July and the notes in relation to that. If Dr Eastgate were saying, as recorded there, in response to the revelations that are included there, "It sounds wrong", is that something that you would perceive as conveying approval or a view that what was being suggested had actually happened?

A My reading of it was that he was saying that what she told him sounded wrong to him.

B

Q Does that smack of approval?

A Approval of the patient?

Q Approval of what she has told him?

A No, it sounds more the reverse. I would have thought him taking it seriously would be more anxiety provoking.

C

Q You have been asked questions about whether the parents should be involved before there was any reference to the child protection co-ordinator or a strategy meeting and you answered that and it is something you have dealt with in paragraph 25 of your report amongst other places. You say at the end of paragraph 25, "It could have made it more difficult for Miss A to open up about her other allegations which subsequently became the focus of care proceedings." I do not want to ask anything about those other care proceedings but, in general terms, what did you mean by that?

D

A That was with the benefit of hindsight that we know there were other allegations as Miss Glynn brought out in her opening statement, but one of the issues that came out early in the evidence and which is certainly the case is we have discussed how sometimes children will make an allegation which tests the water when there is other abuse. I do not think in this case there is any evidence that Dr Eastgate was suspecting other abuse of intra-familial abuse but, with the benefit of hindsight and what we know about other cases, it is also important to hold off and pause before you rush in and tell parents in cases ---

E

Q So, you are saying that generally that is another matter that ---

A ... to be cautious. It is better to be cautious because, once you have talked about it with the parents, there is no going back and especially if there was any question of other abuse, then it would be a problem.

F

MR TURNER: Those are the other matters with which I was concerned.

Questioned by THE COMMITTEE

THE CHAIRMAN: You did speak to the purpose of the notes and you suggested that they were largely an aide memoire for the consultant in the course of his therapeutic practice.

G

A These notes that we are talking about, the description of the sessions, yes.

Q But we know that Dr Eastgate was about to go on holiday and we know that the patient was in a very unstable situation about which whoever was taking over and the junior staff needed to be very well informed and perhaps even be able to make their own judgments in the light of what had happened over the previous few days.

H

Would they not need good notes in order to fulfil their responsibilities?

A A The trouble is that we do not know what went on between him and the staff in the unit in terms of how much time and detail he gave them verbally during that rush time before he went on holiday. I agree that it would be helpful for everybody working with this case to have had a detailed written account of it, but I suspect he would have told them that the girl had made spontaneous allegations and what the nature of those was. He would have kept them very informed about his discussions with the child protection and their job, as he said before he went on leave, was to keep a verbatim account themselves of anything she said. Unfortunately, he had not done the same. I think that, yes, under ideal circumstances, it would have been there but I am not sure that it would have helped them. They knew the nature of it, they knew what was happening, they knew at the strategy meeting and that would be the normal part of hand-overs to the nursing staff and discussion.

B
C Q If I can interrupt, what about the consultant who was taking over responsibility? Did he not need good notes in order that he could take forward the process? I think we did understand that there was a consultant.

A I am afraid I do not know about that because I did not hear the evidence about that yesterday.

Q Another consultant was taking over and was in charge for the next whatever.

D A I think ideally, yes. I think the issue though is that if you are engaged in clinical work and if you have made a decision to refer, as he did, to other agencies in terms of decisions about investigation, you have discharged your responsibilities for investigating, so the girl's clinical state and her management is very, very important, which would be part of the nursing notes. I agree that what she said to him in relation to understanding whether or not there were substantive allegations might have been helpful for the staff in dealing with what was such, I suppose, an anxiety-provoking issue. That is where I think it might have helped them.

E
F MR HARRISON: I just want a little help with your view of the role of a consultant, particularly this inability or ability to deal with something unexpected and rare. I think we agree that the words "bread and butter" do not apply to the rarity. I can also understand that your newly appointed consultant, particularly with your comments about your opportunity for SpRs to get training, might have difficulty. You have described Dr Eastgate as assuming he was the average practitioner but, on the basis of his CV, the fact that he is a trainer and the experience he has had, where would you rate his level of ability to cope with the unexpected?

G A I would rate that I would expect him to be high in his experience and ability at that stage. He had been a consultant for a long time and had had a lot of experience and I think that he did cope with the unexpected, but there is no perfect way of managing a case and, if we all look over any one of these cases that we have been involved in managing or have advised others to manage, one could find alternative ways of managing it. I think he would have had more experience and more ability than most.

H THE CHAIRMAN: There are no other questions or questions arising from counsel, so that concludes your evidence, Dr Hall. Thank you very much for being so thorough and so patient.

H (The witness withdrew)

A

THE CHAIRMAN: We will continue at 2.15.

(Luncheon adjournment)

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