

**GENERAL MEDICAL COUNCIL**

**PROFESSIONAL CONDUCT COMMITTEE**

Monday 8 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 SIX – AM PROCEEDINGS)

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

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

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

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A THE CHAIRMAN: Good morning. A week ago I read the attendance sheet, and inadvertently I failed to mention – because it was not on the sheet – that both counsel are QCs, and I apologise for any inadvertent discourtesy. Also there is no mention of the fact that Mr Andrew Hurst is assisting Miss Glynn, and again I apologise for making no mention.

B MR TURNER: The Lord Chancellor has plans to abolish the appellation in due course anyway, so it is a taste of things to come.

Sir, I only in the event have one witness; the other witness I was going to call has had holiday problems, but I have a testimonial from her in any event. So I will call my one witness, Dr Richard Eyre. I have copies of a testimonial letter that he has written, if that could be distributed, please.

C THE CHAIRMAN: This will be D11. (Document handed and so marked).

RICHARD EYRE, Affirmed  
Examined by Mr TURNER

Q I think your name is Richard Eyre?

A Yes.

D

Q You are a consultant in child and adolescent psychiatry based at Marlborough House in Wiltshire?

A Yes.

Q I think you have prepared a testimonial in relation to Dr John Eastgate, who is a colleague of yours, and your testimonial – a copy of which is in front of you – is dated 28 August 2003?

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A Yes.

Q Are the contents of that document true and accurate?

A Yes.

F

Q If we just flick through that for a moment, we see you set out first of all under the sub-heading “Personal Details” details about your own background, qualifications, training and appointments.

A Yes.

Q Then on the second page under the second sub-heading you set out details of how you have come to know Dr Eastgate.

A Yes.

G

Q You say there that you have been consultant colleagues since October 1994 when you took up your current post at Marlborough House.

A Yes.

Q So you are a junior colleague of his?

A Yes, in terms of our ---

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A Q In terms of seniority?  
A --- line of service – time of service, yes. We have an arrangement within our service – we have four consultant child and adolescent psychiatrists and we each of us have responsibility for our own teams, but there are other responsibilities for the service in terms of management links with other agencies and our own trust, which we share out between us. I am, by consent, known as the lead clinician, so I do a bit more of that linking with outside agencies and representing the service.

B Q You have explained there how you are in separate teams but meet weekly to consider various matters.  
A Yes.

Q Has that always been the case since 1994, that you have had those weekly meetings?

C A I am not sure, between – since we moved into the new building in April 1996, then that certainly has been the case. In 1994 it was a little more difficult, because we were on separate sites.

Q But since April 1994 there have been those weekly meetings?

A Since 1996.

D Q 1996. Further on in the second paragraph under that second sub-heading you say that since September 2002 you have actually been working two days a week with your own clinical patient caseload alongside Dr Eastgate, and you have together a weekly ward round type of clinical review meeting with a multi-disciplinary team.

A Yes.

E Q So you are aware since that practice started of much more about his patients, are you?

A Yes. We do not walk out of the room when we are discussing each other's patients; we are there together in the discussion.

Q Before September 2002 when that practice started, did you ever have any involvement with or responsibility for Dr Eastgate's patients?

F A Occasionally, in the capacity of providing consultant psychiatric cover for the team on the unit, if Dr Eastgate was absent.

Q What form would that cover take? Would that exist if, for example, Dr Eastgate was away on holiday?

A Yes.

Q What form would the cover take?

G A Usually what would happen is that before Dr Eastgate went away, then there would be a conversation, and either myself or my colleague Dr Woodhouse would agree that we would be providing some cover – either one of us or between us – and Dr Eastgate would hand over very briefly what was going on with each of the patients, sometimes with a typed paragraph, sometimes with a handwritten note, and some discussion.

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- A Q So there would usually be some form of document, either handwritten or typed, and some form of discussion?  
A I think it would be fair to say that that would be the case for patients where there was a degree of, if you like, concern or issues outstanding that could come up, then I think there certainly would be. I think at other times it would be a summary, if you were away for a few days, saying – well – perhaps one or two of the others there would not be something written, because there were not any immediate issues that were expected to be of concern over that period of leave.
- B Q In Dr Eastgate’s absence would you have access to and contact with the other members of his team?  
A Yes.
- C Q Would you expect them to be familiar with ongoing concerns and issues regarding individual patients?  
A Very much so, yes.
- D Q To what extent would you personally be involved, in general terms, during such periods of absence of Dr Eastgate?  
A I think that depends on one or two factors. One factor it depends on is the length of that anticipated absence. If it was only going to be a couple of days then I would be available, really, to the team. If it was a substantial period of a couple of weeks, then I would see it as my duty to actually go into the unit and talk to the senior nurse. If there is a senior registrar or specialist registrar, as I now know, then I would expect that person to be able to carry the medical responsibility at the clinical ward round meeting, linking with me as necessary. If that person was not there then I would hope to – and indeed have done on several occasions – attend the ward round meeting myself and join in the team discussions.
- E Q In the normal course of things would you expect to have hands-on dealings with the patient?  
A Not unless there were any new situation or change in their presentation that warranted that. I would expect the multi-disciplinary team involved in their care in the normal course of things to continue doing that.
- F Q Would you have access, in addition to any hand-over note that Dr Eastgate had given you, to his file notes and the nursing notes?  
A I would. I would, yes, but in the case of his absence it would not be the case that if he were to be away for a short period that I would go along and read through all of them from start to finish, in this position of providing psychiatric cover to the team.
- G Q If you were providing psychiatric cover during a period of Dr Eastgate’s holiday and there was a patient who was an in-patient in the unit, who was one of Dr Eastgate’s patients, and that patient had in the recent past been making allegations of sexual abuse, how much detail would you need to have of those allegations to serve your purposes in providing cover?  
A The exact detail of the allegation I would suggest I would not have need to know of. What I would have need to know of is whether the appropriate responses to those allegations were being made, and whether clinically in terms of that young
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A person's emotional and behavioural difficulties they were being appropriately responded to by the team.

Q When you say whether the appropriate responses have been made, what do you mean?

B A Sitting down in a ward round meeting I would want to know, for instance, whether the local child protection procedures had been followed, whether there was a social worker working on the case, whether there was a child protection investigation. I would also want to know, I think, how the young person clinically was responding to the way that that system begins to operate.

Q Would you need to have details of the precise words that the patient had spoken when making the disclosure or the precise questioning that had led to the disclosure?

C A No.

Q Do you recall now whether you provided cover for Dr Eastgate in July of 1996, when he went away on holiday?

A No, I do not recall that, I am afraid.

Q So you are not saying you did not, but you cannot say you did either?

D A Indeed.

Q You also go on in your testimonial letter, in the third numbered paragraph, to make observations setting out your opinion of Dr Eastgate as a clinician.

A Yes.

Q In what regard do you hold him as a clinician?

E A I certainly respect him as a clinician. As I mentioned, I have never observed Dr Eastgate working one to one with a patient, and there is no clinical reason why that should happen. So I suppose my experience is limited to not only the multi-disciplinary discussions that we have within Marlborough House, but also times when I and he may talk about cases in those Monday meetings, as we sometimes do; that is another function of those meetings, if we have particularly difficult cases, then we would rung them past our colleagues both for support and for new ideas.

F Q Do you ever have dealings yourself with members of the child protection team in Wiltshire?

A Oh, yes, I do.

Q Do you ever look to members of that team for advice at all?

G A Yes, very much so, particularly the child protection coordinator. I work nowadays in two teams: I work in the in-patient team but I also have had substantial caseload numbers in out-patients. I provide clinical supervision to various people, but in particular to clinical nurse therapists, and for the team, in an out-patient capacity, they would see me as a resource, I suppose, to discuss difficult cases with, and some of those inevitably are cases with child protection concerns. It has been my practice that when I have had concerns where I may have been uncertain about a threshold being reached or I suppose the quality of information that was coming, that I would actually contact the child protection coordinator and consult and take advice, if I was

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A uncertain of the next way to go. I would also advise my team members to do that as well.

Q If you are involved in a therapeutic one-to-one session with a patient, is it your personal practice to take notes during the consultation?

B A It depends what the context is for that consultation. An example I would give would be a first assessment, when a young person, for instance, comes to the adolescent unit, having been referred, then we would see them with their family, we would see them with a multi-disciplinary team, and a part of that afternoon session would be an individual interview with the young person, which I might well conduct. In that situation I think I would inevitably be making notes – they may or may not be verbatim, but they would be notes that would help me define as well as I could issues to do with mental state examination, and the initial presentation of that young person in the interview setting. So that is one context.

C Another context might be, for instance, if I were called in by the team because there was a problem, but it was not an ongoing patient of mine, then again I would be called in very much to be making an assessment as to how I could help with my opinion for the team and for the ongoing management of that patient. I think then I would be more likely to be making notes – again, not necessarily verbatim ---

D Q Is it possible to make verbatim notes?

A I think it is very difficult. People do try to. I do a lot of medico-legal assessment work for the courts where I am making notes a lot.

Q So that is a further type of context?

E A Yes. And over several hours of interviewing – I will see a family all day in their home – one is trying to get as much of the relevant comments down as possible, whilst having a reasonable engagement with one or more people. So it is hardly possible to be verbatim. But in that situation of medico-legal assessments one would be trying very hard, because you are going to be – you know that what you do make notes about is going to be cross-examined carefully, and you are going to be making clear recommendations for others to follow as a result of that.

F If we move to the therapeutic situation where one might be doing some ongoing work, perhaps weekly sessions over several weeks, or even months or years, then I think the context is different, and it certainly would not be my practice to have a note pad in front of me if I was working on a weekly basis with an adolescent; it would be my practice to be making notes or dictating notes probably afterwards, as soon as possible after the session had finished, so there is a clear record of what has been happening.

G Q Is it always possible immediately after the session?

A Not always, no.

Q Why not?

A I think it would be known as the pressure of work, really. Sometimes you end up doing administrative tasks, even though it is a clinical task, towards the end of the day. If you have people in the waiting room then you have to strike a balance, really, and be expedient.

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A Q What about a situation where a patient may unexpectedly make a disclosure of sex abuse in the course of a therapeutic session?

A I think the first task is to try and make some kind of judgement as to how that disclosure has arisen, how it relates to the other things that have been coming before that in the therapy, and then I would want to be satisfied that the young person is, if you like, safe and able to continue in discussions at a further time, so that there might, for instance, be a difference between an in-patient and an out-patient setting. If I felt that the supposed disclosure was either unclear or difficult to understand, then I would probably want to talk to colleagues afterwards; I might decide that I wanted to leave it to a further session, if I felt that it was not a clear disclosure. Usually I think I would be wanting to talk to colleagues after a session where it was unclear. If I felt that the material was of such a nature that I would need to be ensuring protection, and the possible investigation of that material, then I would need to tell the young person that I would have to share that information outside of our meeting.

C Q Would you be making notes during those continuing sessions, during the session ---

A During the continuing sessions I think I would be more likely to wish to do that, having got to that point where these concerns were now in my mind. But I think there is a tension, which most clinicians will recognise, between the investigative process in child sexual abuse and the therapeutic process. I would not necessarily see it as my duty from that point to be conducting interviews that would be investigative and of value to the child protection process. I would really be advised if those types of interviews needed to be carried out by the child protection team, having consulted them.

D Q Moving back to Dr Eastgate, on the third page of your testimonial letter, in the last paragraph, you move on to talk about his personality.

E A Yes.

Q Is he available to help colleagues who need help?

A I believe he is. I have worked with several child psychiatrists, consultants, I suppose, over the years, although only with a small number in my recent career, but certainly as a more junior doctor I met quite a few. I always find him to be available if I did want to talk about a clinical problem or something that was coming up. If I wanted to swap an on-call day, we are fairly flexible within our service and able to do that. I do not find him to be in any way a rigid, inflexible person at all.

F Likewise, with the multidisciplinary team, we have colleagues of other disciplines who from time to time will be, I guess, not just struggling with things in terms of their clinical workload, but in their personal lives. I can think of one or two examples recently where, as a consultant in a team that has been together for quite some time, you want to support your colleagues on an emotional level at times, if that is possible. I certainly know that Dr Eastgate has been able to do that in the past and, in fact, in the fairly recent past.

G Q Is he in any sense an impetuous man who fires from the hip, acts first and thinks afterwards?

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A A Not in my experience, certainly not clinically. I think every now and then - I may be occasionally guilty of the same thing - in contact with our managers at times when we are trying to ---

Q This is administration you are talking about, is it?

B A It is administration and it is trying to get the resources for a service with a one-year waiting list, etc, and frustrations at bureaucracy. When you are having a new building built, for instance, and then you move in and you find that the showers will not work for these very troubled teenagers who are living there for several months, things like that, then Dr Eastgate would certainly make his feelings known on things like that because they do not serve young people well.

Q In so far as you are able to judge, what, if any, effect have these proceedings hanging over his head had on Dr Eastgate?

C A I cannot say that I really know. I cannot imagine. He does talk to myself and my colleagues, not just the consultants, one or two other members of the service as well, about what is happening. I think my impression is he may well have slightly cut back on the intensity of his workload as a result and partly because we wanted him to and because it is a good thing.

D I think at times he has been a little despondent, frustrated. I think he has used his colleagues well to share some of that and to help ensure that the clinical load was attended to appropriately, really. I have not really experienced him in a clinical setting either talking about these things or seeming to be, whatever it is, impetuous or miserable to the degree that he could not keep thinking about the clinical task at hand, but I do think it is a difficult situation.

Cross-examined by MISS GLYNN

E Q Dr Eyre, you have given evidence about the situation that would apply when a consultant goes on holiday or goes on leave.

A Yes.

Q I think your evidence is that you cannot recall now what the position was in July 1996 when Dr Eastgate went on leave on 19 July ---

F A Yes.

Q --- in terms of who took over his workload. Are you able to comment on the fact that during that three-week period there appear to be no notes in relation to the patient with which this Committee is concerned, Miss A, compiled by a consultant? Certainly no notes compiled by you?

G A No. Am I able to comment on it? I would have thought that there would be notes of the weekly clinical meeting, which would not be directly compiled by a consultant, but would be the outcome of the team discussion and review each week. I do not know whether that is the case. I have not looked at the file.

Q I think what I was really asking you, Dr Eyre, is are you able to agree, first of all, that there are no notes compiled by you during that period about Miss A?

H A If that is the case with the file, then I am certainly able to agree, yes.

- A Q You have no recollection of seeing Miss A ---  
A No.
- Q --- in consultation during that period?  
A No, I do not.
- B Q Do you have any recollection of any conversation between you and  
Dr Eastgate before he went away specifically about Miss A?  
A No, I do not. I have no recall.
- Q You certainly do not have a note of any conversation made between you and  
Dr Eastgate before he went away about Miss A?  
A No.
- C Q Would that be right? Could I ask you to take up the Committee bundle,  
please, C1, which somebody will help you with, I hope.  
A Yes.
- Q I recognise that you have given evidence to the Committee that you had no  
direct dealings with Miss A during that three-week period yourself?  
A I do not recall having direct dealings, no.
- D Q Could I ask you to turn to tab 1, please, page 24, and confirm to the  
Committee that you have never seen that document before?  
A I do not recall having seen it before.
- Q Can we take it, therefore, that you have also not seen Dr Eastgate's file notes  
concerning Miss A either; would that be right?  
E A What I am saying is I do not have a recall of the specific contents. I do not  
know whether I may have had occasion to read them during a period or not.
- Q As I understand your evidence about note-taking, you were asked by  
Mr Turner whether after a session during which there was some indication that there  
might be sexual abuse being disclosed by a patient, you would during continuing  
sessions be more likely to want to make notes, I think that was your evidence?  
F A Yes, or have a pretty full note after the session.
- Q Does that reflect your understanding that the point of first disclosure of sexual  
abuse is a very important point both in relation to the treatment of patients and also  
potentially forensically later?  
A Yes.
- G Q If I could ask you, please, to turn to tab 2 of the bundle that you have in front  
of you and look, please, at page 7? I appreciate, Dr Eyre, that you have not seen this  
before and I do not wish to take you by surprise in any way. Is that right, you have  
not seen this document before?  
A I do not have a recall of having seen it before, no.

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- A Q That is fine. If we can take this very briefly, what appears to be happening here is that the session is being conducted primarily in order to examine or explore Miss A's feelings that people had let her down. Do you see that first paragraph?  
A Yes.
- B Q People whom she had talked to or had made promises who somehow or other had then gone away. So that appeared to be one of the presenting problems at this stage, yes?  
A Yes.
- C Q Certainly the topic of the session at the beginning. There is then a conversation during which in the second paragraph Dr Eastgate asks various questions in the alternative. No criticism of that. Do you follow me?  
A Yes.
- Q  
"Male or female? Family? - no it wasn't - was it somebody she had known a long time? - No it wasn't. Was it somebody in T? No - Was it somebody at Lady Eden School?"
- D Then as we go through the rest of that page, Dr Eastgate appears to suggest to Miss A that it sounded as though it was somebody in London, a medical person.  
  
"I asked whether it happened once or a number of occasions",  
  
until a little further on:  
  
"I then asked [Miss A] when she first felt uncomfortable and she said when she was nine."  
  
Right?  
A Yes.
- F Q I am not asking you for your opinion about that for the moment, but the clear evidence that has been given is that Dr Eastgate at that stage was aware that something significant may be emerging in this session, do you follow me?  
A Yes.
- Q And that would be quite reasonable in the circumstances, would it not, looking at this note?  
A Yes.
- G Q That you would be on notice that something may be emerging of significance to this child's treatment?  
A Yes.
- Q Indeed, that is a fairly long note reflecting that point. It was an important session, yes?  
A Yes.
- H

A Q If you turn over the page, at the top of the page there, "Afternoon session, 9 July", so the same day, but later on that same day, we have what would appear to be the first specific disclosure of sexual abuse at the hands of a medical practitioner, a senior medical practitioner:

"She moved on to talk about how at 9 her breasts were stroked by Professor X",

B as we are calling him,

"and he touched her in other intimate places. This felt uncomfortable and wrong, but she didn't know what doctors were supposed to do. She felt she was probably responsible for what had happened. She was surprised when I suggested that not only did it sound wrong to me but I was worried that he may have done it to other children as well."

C That note of that session, the first disclosure, a specific disclosure, of sexual abuse is five lines and three words long, and it does not appear to contain a verbatim record of what was said, does it?

A No.

D Q Would you agree, on the face of it, that note, in your experience, would be wholly inadequate for a first disclosure session?

A I think I might want - I suppose try to write more myself of what had been talked about.

Q And the context in which the first disclosure had been made, the way in which the questioning had proceeded, would that be right?

E A I am less sure about that because it seems to follow on, I suppose, from a session earlier in the morning about context, but certainly, yes, some indication of what questions I had asked I would probably want to try and recall.

Q Which would give the context in which these allegations, the specific allegations, had been made, would it not?

A Yes.

F Q Indeed, you would want to attempt, so far as possible, to record this session in a verbatim manner, as near as possible to verbatim, would you not agree?

A Yes. I would want to try to remember what the young person had said.

G Q You, I suggest, in accordance with the principles well-known at that time, would have been very keen not to say or do anything that would influence the perception of the child about your opinion of what had happened to her; would that be correct?

A It would. I guess, from what I am reading, there is one point of clarification on that, which is the issue of how one responds to, I suppose, a young person expressing feelings of guilt and responsibility, because there is an issue about how and when you help them have some containment or a framework which allows them to feel that, well, perhaps there is not a justification for you feeling responsible for having either said this or felt it.

H

A

Q Exactly, that she should not blame herself for having said this?

A Indeed.

Q Or should not feel responsible, is that right?

A Yes.

B

Q Is that what you would be very keen to impart to the child?

A Yes.

Q Are you surprised by the last two lines:

“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.”

C

Do those lines surprise you, Dr Eyre?

A I think written baldly like that you can read, you know, different things into it. I guess I would feel that I would want to know more of what the conversation actually was.

D

Q Can you see any possible reason why he might have mentioned in this context his concern that the medical practitioner might have done it to other children as well? Can you see any justification for that?

A I am not sure. I can understand that type of communication happening around the disclosure or explaining the disclosure process and why one would be moving towards child protection proceedings; so again it depends on what the conversation actually was that was happening.

E

Q This is the first disclosure of a specific allegation of child sexual abuse. You can see from the next entry for the 10th that the child protection procedure is discussed then. Can you see any justification for mentioning concern that he might have done it to other children as well in that first disclosure session on the afternoon of the 9th? I suggest there is no justification for it. Would you agree?

A I think, yes, on that information that is in front of me, or that paragraph, yes, I am not certain I would have said that.

F

Q Now turning to page 10 of the same tab, Dr Eyre, if you would, please, there is a file note there for 16 July 1996 at the bottom of that page - I should put this into context for you, this is after a strategy meeting has taken place, all right?

A Yes.

G

Q At the bottom of that page, there is reference to how interviewing or therapy sessions should be conducted with Miss A. We are talking about therapy specifically, but in the context of information-gathering. Do you follow? So if we look at the note, this is the bottom paragraph, four lines down:

“I appreciate that this will largely be work [Miss A] may do with Mel rather than myself. My understanding is the Child Protection Agencies are happy for this work to continue as they see that it is in [Miss A’s] best interest. But at the same time it is important that all discussions, whether with nursing staff or

H

A other clinical staff, are written down as nearly verbatim as possible, and that no leading questions are used in trying to elicit information. Thus it is quite reasonable to ask [Miss A] 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.”

Presumably none of that takes you by surprise does it?

B A No.

Q It is simply setting out principles that would apply in a therapeutic context where you are seeking clarification, is that right?

A Yes.

C Q Could I ask you to turn back to the document I asked you to look at just now, which is tab 1, page 24. You will see that this is a letter from Dr Eastgate to Mel Smith, who I am sure you are familiar with?

A I do remember her, yes.

Q This letter is dated 19 July and is a letter from Dr Eastgate to Mel Smith, and it refers to a session which we have established took place that day before Dr Eastgate went on holiday.

D A Yes.

Q I want to ask you about the second paragraph, please: It reads:

“Secondly, [Miss A] told me this process of her going to see [Professor X] started when her parents looked at her and said, ‘[Miss A] 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.”

E

On the face of it, would you agree that this appears to be the first mention (you can take it from me there is no other mention before this) of some potential problem concerning her father?

A Yes.

F

Q This is the only note of that session that exists. There is no file note whatsoever, and the evidence has been that, as well as what is in this note, Miss A mentioned something about being touched intimately and also on the breasts by her father. In those circumstances, would you agree that this record of that session is wholly inadequate given its contents?

G A Well, I think I would have wanted – it is hard to say because I do not know the context of the session - but more detail as to what she actually said.

Q Yes, particularly given that the doctor was going away on holiday that day and leaving her care to other people, do you agree?

A I suppose I am less certain about that because I am not clear what the agreement was in terms of what workers were going to be doing over that time.

H

A Q Would you have made a note as brief as this in those circumstances, excluding the features of the sixth session that specifically may have translated in the interviewer's mind to being an allegation of some sort of abuse, namely that it was intimate touching and in the area of the breasts? Would you have made a note of this sort?

B A Obviously this second paragraph does not make it clear as to what you have just said, whether it was intimate touching or not. If it was then I think I would have wanted to communicate that.

Q You have provided in your testimonial information about Dr Eastgate's character, and you have made reference to a problem that there appears to have been between Dr Eastgate on the one hand and a psychotherapist on the other hand.

A Yes.

C Q You stated that Dr Eastgate was seen by that therapist as "blunt and unreasonable" – I am referring to page 3, the penultimate paragraph – "but careful consideration over the subsequent months has demonstrated the colleague to be out of step with the team – not Dr Eastgate."

A Yes.

D Q In your view of what happened was it understandable that the psychotherapist should regard him as blunt and unreasonable?

A Sorry, I do not understand the question.

Q Was it understandable that the psychotherapist should have regarded him as blunt and unreasonable, given what happened?

E A No, I do not think so. I mean, this is a matter that is still going on now within the service and the person is concerned – I am in regular meetings with her professional manager and we continue to have concerns.

Q Do you know on what basis the psychotherapist formed the view that he was blunt and unreasonable?

A I think it was over a clinical disagreement really, as I understand it, psychotherapeutic work within the adolescent team.

F Q Yes, and he expressed his views in a blunt way which she felt was unreasonable, is that what you are saying?

A All I can say is that that is what she felt. I was not there, obviously.

Q Of course not.

G A But I suppose what I am saying is that since that time, since joining the adolescent unit team – and we do not just meet in clinical meetings, obviously we have management meetings etc. – I think it is the case that be the family therapists, clinical psychologist, head of nursing, have all been clear really about what I would have to call unreasonableness of that particular person and rather trenchant views formed out of an over-sensitivity and what I think is an over-identification between her own sense of her own competence and self-esteem and the acceptance of the model with which she works, and that has been a problem.

H Q In any event, you have described Dr Eastgate as a man who speaks his mind.

A A Yes.

Q There are circumstances when any of you consultant psychiatrists speak to a member of the child protection team when it is inevitable, given the circumstances, that there is going to be a referral, are there not?

A Yes.

B MISS GLYNN: Thank you very much Dr Eyre, I have no further questions.

Re-examined by MR TURNER

Q Dr Eyre, Miss Glynn has pointed out to you that nobody appears to have found any consultant notes in relation to Miss A covering the period when Dr Eastgate was away in July/August 1996.

C A Yes.

Q Does that surprise you?

A No, not necessarily. If a young person is an inpatient, sometimes that may be for a few months, sometimes it may be for many months, as I said earlier, if there is a plan for that young person, with involvement of the multi-disciplinary team appropriate, and there are no major concerns with regard to change in mental state or behaviours out of the ordinary that would indicate a need for an urgent reassessment, I would not necessarily expect to be approached in order to reassess a young person during that holiday period. I suppose I might also ... I am just thinking about whether or not, you know, it is relevant as to the presence of the specialist registrar, as I said earlier, if one had a specialist registrar on the team. Again, they might well be involved in day to day discussions with the team as to how things were going but if there were no immediate concerns then they would not necessarily make a clinical entry. The clinical entry should come weekly with the Monday meetings.

E Q You speak about the Monday meetings, they are the clinical meetings are they?

A Yes, that was the title, yes, "clinical meeting."

F Q Would you look at tab 3, page 11. These are nursing notes that we are looking at now, just to put you in context. We see at the middle of that page a nursing note relating to what appears to have been a clinical meeting on 22 July 1996, and we know that was the Monday after Dr Eastgate had left to go on holiday.

A Yes.

Q Would you have expected one of the consultants to be present at that clinical meeting?

G A If possible, yes, or the specialist registrar.

Q We see there: "Continuing disclosure work with JE" – so that would be John Eastgate, presumably?

A Yes, that what I would imagine.

Q "MS to spend time with [Miss A]." Do you know who MS was?

H A I presume that is Mel Smith.

A

Q So Mel Smith:

“... to spend time with [Miss A] during John Eastgate’s absence on holiday. Concern expressed over self-harming, feel if there was a major problem, i.e. infection etc., [Miss A] would inform and co-operate with staff. Feel mood is generally better – more chatty with staff and peers. Allows close observation when in her room to ensure safe environment.”

B

If you turn then to page 14 we see a note dated 26 July, do you recognise the signature on page 15?

A It says Staff Nurse ...

C

Q Was there a Staff Nurse Stephenson there at the time.

A There may well have been.

Q Tanya Stephenson.

A Stephenson, yes.

Q The note says:

D

“[Miss A] disclosed important information to day to me after peer Laura had said [Miss A] needed to talk to me. I asked [Miss A] if she wanted to see me and she said yes. (See individual notes for disclosure). Social Services have been contacted, and the police.”

Would you have expected any reference to be made to a stand-in consultant prior to that?

E

A I am not sure really. The entry implies a clarity about what needed to happen. I would imagine that there was discussion with the senior nurse on the unit, with or without the multi-disciplinary team and the Monday meeting, but it is not clear how that happened.

Q If a consultant was consulted, there does not appear to be any file note by that consultant.

F

A No.

Q Moving back to another topic about which Miss Glynn asked you questions. If you heard from a young female patient an allegation that a paediatrician had touched her in a way which, if it was true, the allegation would be a wholly inappropriate way, would you be concerned about the potential for risks to other children?

G

A Yes, if I formed the impression that it was an allegation that had any possibility, I suppose, of being true.

Q Should one be honest with one’s patient about one’s concerns if one has such concerns and there is a possibility of reporting?

H

A I think it is important to give young people information if you are going to act on what they have said, yes.

A Q Should one explain what one is doing to the patient?

A One should explain what is going to happen with the information. I think the issue of being honest about your concerns is less clear, but I think those are conversations that probably do quite often happen actually in the process of investigation in child protection cases, that there is a degree of communication with the young person which is both, I suppose partly reassuring, reassuring them that they are right to actually speak out about things, and the possibility that other young people may or may not be harmed comes into that. I think it is a question of timing as to when those kind of communications may or may not be made.

B

MR TURNER: Would you wait there in case members of the Committee have questions.

Questioned by THE COMMITTEE

C

MR HARRISON: Doctor, you have referred quite a lot to a specialist registrar taking some of the clinical load, which I can well understand. In this case Dr Eastgate said although there was a specialist registrar he was not involved at all – in fact he even said he did not know what he was doing during this period. Was any other doctor involved? Did you have SHOs who would carry some of the clinical load?

D

A No, unfortunately we do not have SHOs who would carry some of the clinical load. We have occasionally SHOs who would tend to be in the outpatient setting and spend time on the adolescent unit really more in observational capacity. Only once have we had an SHO who came and worked on the unit and that was more recent.

Q So this really was a consultant-delivered service?

A Yes, from the medical point of view. I mean, it was a team-delivered service.

E

MR HARRISON: Yes, I understand. Thank you very much.

THE CHAIRMAN: If there are no other questions from the Committee, that concludes your evidence. Thank you coming to assist the Committee, you are discharged and free to go.

(The witness withdrew)

F

MR TURNER: Sir, finally I have a bundle of testimonials that I would seek to put before the Committee at this stage.

THE CHAIRMAN: It is rather unusual to have testimonials at this stage.

G

MR TURNER: Sir, I know that sometimes it is done. It is certainly analogous with the criminal type of proceeding where, of course, if there are is any issue of credibility it may go to that aspect.

I do not know if you wish to take the advice of the legal assessor.

THE CHAIRMAN: I will ask the legal assessor, but I am very conscious of our need to remain focused.

H

A THE LEGAL ASSESSOR: My advice would be that, indeed, this sort of evidence can be relevant to credibility, and there are one or two issues in this case where perhaps what Dr Eastgate says has been challenged and may have to be tested by the Committee. But I would also advise the Committee that to err on the safe side, one should admit evidence that the defence wish to have at any stage.

B THE CHAIRMAN: This bundle will be D12, and the Committee will read through it.

MR TURNER: I wonder whether the Committee would wish to do that in private, or for me to take the Committee through it? I am happy with either course.

THE CHAIRMAN: I think they can read it over the coffee break, which they could take immediately.

C MR TURNER: I think that would be satisfactory. Can I just mention, I think it will be obvious from the documents concerned that several of the letters which will be found in there are letters which have appeared unsolicited during the course of these proceedings, and indeed one of them was actually sent to the GMC which was then – I am very happy to say – passed on to us. It will be apparent which ones those are.

D THE CHAIRMAN: Does that then conclude your ---

MR TURNER: That concludes my evidence.

THE CHAIRMAN: We will take a break now, and continue at half-past ten.

(The Committee adjourned for a short time)

E THE CHAIRMAN: Miss Glynn, your closing submissions.

MISS GLYNN: Sir, the first thing I am going to ask is that the skeleton arguments are distributed to you, which I hope will assist you as I go through these matters.

THE CHAIRMAN: Thank you very much.

F MISS GLYNN: I am very conscious of the requirement that this should be done as quickly as possible, but consistent with my duty to put forward all the relevant matters, so I am going to use the skeleton, if I may, as I go through the closing submissions, but not read every part of them.

THE CHAIRMAN: That would be most helpful. This document is C6. (Document handed and so marked)

G MISS GLYNN: If I can explain the way the document is structured, I have sought to deal with the heads of charge in the order in which they appear in the notice of inquiry, starting off with heads of charge 3 and 4. Before one looks at the allegations there specifically, I have set out what I think is the relevant literature and guidance on these topics, and sought to deal with the debate that has taken place during the course of this hearing about the difference between investigative or therapeutic sessions.

H

A In our submission, in the context of these allegations, that distinction is immaterial. It is not in dispute that relevant principles of good practice as highlighted in the literature would apply in the instant circumstances, in other words that the doctor should conduct the sessions by not leading, using open-ended questions, not influencing the child in what she says, should not transmit the opinion of the interviewer about what is being said, and should keep as near verbatim, accurate records at the time or as soon thereafter as possible of the session.

B Then I have set out at the bottom of page 1 passages from Professor Zeitlin's evidence, who I have referred to a 'PZ' throughout the course of this document, which you may find helpful when looking at that aspect of the case, although in my submission it really is no longer controversial.

C The passage that I have cited at the top of page 2, Day 2/24G, may be the most important:

“Once there is a suggestion that there could have been inappropriate behaviour towards the child, then certainly it is extremely important to avoid leading the child in any way at all. Secondly it is extremely important not to convey an opinion to the child. Concern and an opinion about the nature of the actions are not the same thing. You can express concern, but not an opinion. And thirdly, to have made sure that there was detailed verbatim ... recording.”

D Sir, that, if you like, encapsulates what in my submission is the agreed evidence after testing of all the medical practitioners skilled in this field during the course of this hearing.

E Professor Zeitlin said the time came when the sessions became investigative in the sense that there was a requirement to seek information, and that is quite clear from the file note of 16 July, where there is specific reference to eliciting information. But, nevertheless, that is a therapeutic session, and there is no suggestion that these are anything other than therapeutic sessions. I have set out that file note there, because it may assist you on this topic.

F Paragraph 1.3: Dr Eastgate agreed that a doctor cannot provide therapy unless he knows what the child says happened to her. A psychiatrist cannot provide effective therapy if he adopts techniques that influence what the child says, and her perceptions, and that may cause false allegations to be made. So there you can see that that point is not in dispute. It is agreed by Dr Eastgate.

G Then I have dealt in paragraph 1.4 with the topic of leading questions and the situation in which it may be appropriate to facilitate – again, not relevant in this case. It seems to be agreed evidence that you should only use facilitative techniques where the child is in grave danger, there is a pregnancy, or whatever. No-one has suggested that this is such a case. Indeed, Dr Eastgate confirmed that he knew of no literature that endorses leading and transmitting the interviewer's views in a therapeutic session.

H Then paragraph 2 deals with the fact that we are not dealing here with counsel of perfection. The principles set out in the literature are not esoteric. I have cited the passages from Professor Zeitlin there which are relevant to that. The issues had been

A “very publicly aired” from the time of Cleveland; “there was a major public airing of techniques and the errors and fallacies that could arise”.

Then I have gone on to look at the specific allegation at head of charge 3, which of course is the first session on 9 July, alleged leading, and set out there what we submit are the principal transcript references, but of course you may find other references that are useful and Mr Turner may direct your attention to other references. But I have cited there Professor Zeitlin in chief and Dr Eastgate in cross-examination, and there will indeed be some references to him in chief as well.

The principal literature references are Jones, page 45, and *Working Together* – that reference that I have set out there.

C In our submission the context in which that first session on 9 July took place is very important, and I have set out what we submit are the relevant features of it, with bullet points, in paragraph 3.1. It is quite clear that this child had a dislike of medics, whether male or female, which may well be relevant as well to how that session was conducted.

D Paragraph 3.3 deals with the fact that we are looking at a child who by this stage was gradually beginning to talk more freely, so this was not an exceptional case where you had a child sitting there refusing to say anything, curled up in the corner. She was clearly unfreezing, which is one of the words used at the reference tab 1, page 14, and other references there through until the period we are concerned with on 9 July.

E Then, very importantly, we submit, at paragraph 3.4, this reference here to what Dr Eastgate described as the child being concerned about whether he might be cross or angry or refuse to see her again if she told him something that did not meet with his approval, and the fact that she was emotionally needy. Both the references are provided there, if you need to check them. That is Dr Eastgate’s evidence-in-chief.

F At paragraph 3.5 we have set out what we say are the principal criticisms of that first session, in four bullet points there, citing Professor Zeitlin’s evidence. He talks about there being “quite a radical change” between the second and third paragraphs, the key words being “I suggested”, and he refers to this part of the session as being “hazardous” or “quite hazardous”.

With reference to the word “uncomfortable” he said:

G “I could not find any previous reference to the girl talking about feeling specifically uncomfortable. There is anger, there is resentment, there is clear evidence that she did not like the person concerned, but this is introducing ... another element. There is the person, there is reference to ‘it’ happening, and now we have reference to ‘it’ being her being uncomfortable.”

Then another quote from his evidence:

H “The position at this point would be as to whether the doctor had been forming the opinion that something untoward had happened. If he did not, it becomes more difficult to explain the nature of the questioning, and, I’m afraid, if he

A did, he would have been aware of the need to avoid as much direction and suggestion as possible.”

B Dr Hall agreed in chief that it was very unfortunate that Dr Eastgate had used the words “it” and “uncomfortable” because of the association with sexual abuse. You will appreciate, sir, that when I drafted this document I did not have access to the transcript for Dr Hall and Dr Bentovim. Mr Hurst has looked at the transcript this morning, and could I give you some references, please. Day 5/11E; and Day 5/4E-F. These are passages in which Dr Hall states that “all abuse has to be in mind in undertaking therapeutic work where you have a disturbed child”; and Day 5/33D, she then said that “sexual abuse would not be in mind on 9 July”, but then conceded that “it would have to be, in these circumstances”. That is Day 5/34F and Day 5/35C-F.

C I shall be making observations about Dr Hall’s approach to this case, and indeed Dr Bentovim’s, later; but I would ask you to highlight as we go through the apparent changes in Dr Hall’s evidence, the inconsistencies in it. She appears to be struggling throughout the course of her evidence to find excuses to be acting as an apologist, we submit, for what happened, but then does have to make concessions – and I will try to highlight those as we go through.

D Day 5/34C-G, she says that he would indeed be trying to find the cause of the depression at this time.

E We highlight in paragraph 3.6 that this was not, during the material stage this Committee is looking at, a complex case. For a specialist in this field the importance of asking open and non-leading questions should have been clearly understood and complied with. Indeed Dr Eastgate stated that “therapy is a very powerful tool and you have to be very careful how you use it”.

So that is the evidence in relation to head of charge 3. Head of charge 4, of course, relates to the second session on 9 July, the allegation there being one of influencing the child by transmission of an opinion of the interviewer.

F Professor Zeitlin’s opinion in relation to that is set out at paragraph 4.1, and of course the Committee will have appreciated a long time since that the allegation there is based on that last sentence in the record, “sounding wrong”, “he may have done it to other children”. Professor Zeitlin said:

G “There is a very specific reference. It is endorsing to the child that something has been done wrong. It is no longer in any way an open interview, and there is unfortunately a high likelihood of influencing the child’s perception of what she has said and is saying ... this is an angry, resentful, miserable ... child, who might well be looking for justification of her feelings. It may be that something untoward had actually happened, but once you transmit an opinion ... different from saying ‘go on, I’m concerned’ ... this is quite different. There is a high risk of influencing the child so that it becomes difficult to interpret what the child says.”

H Then he goes on to cite some examples of correct questioning in circumstances which of course is open-ended and non-influencing.

A Paragraph 4.2, very important, in my submission, and I would suggest, with respect, that you look at that passage there at Day 2/26B:

“If techniques are adopted that risk assigning to a child a victim role, that perception of the child may continue, which risks muddying the waters.”

B I have cited a passage from Jones there:

“One has to be cautious to modulate one’s own emotional response”.

I have repeated the evidence that comes through all the witnesses in this case, I submit, that at this stage the case was not abnormally complex or difficult. Indeed, Dr Hall accepts that, and I will give you the reference, if I may: Day 26/26F-H.

C Dr Eastgate stated that between the two sessions he was concerned about developments in the earlier session, and the reason he had a further session that day was because he felt that Miss A had something more to say. He agreed that in circumstances such as these the principles that apply to not influencing the child are exactly the same whether dealing with investigation or therapy. He was on notice of the requirement for caution. This was not a case in which the therapist was “shocked” or under a “burden”, to quote Dr Hall, in a way that can excuse what happened.

D Indeed, if I may pause there, having had a chance to look at the transcript of Dr Hall’s evidence, Dr Hall accepts that it is important not to influence a girl looking for approval and a girl who is emotionally needy. That is Day 5/29E-F and also Day 5/36E-F.

E Dr Hall ultimately said that she would have thought and consulted before she – quote – “risked saying to her that it was serious enough to speak of other children”. That is Day 5/39C-D. That, we submit, is an important concession. She would have thought and consulted before she risked saying to her that it was serious enough to speak of other children.

F We comment in paragraph 4.3 that the evidence from Mrs A about being told on 12 July that Dr Eastgate was 98 per cent certain it was criminal, in front of Miss A, may shed some light on his approach to not influencing Miss A by expressing his own opinion on 9 July. It is a matter for the Committee, but we suggest that that is relevant evidence when considering his approach generally.

G At paragraph 4.4, we set out the evidence there of an opinion or a view being reached at an early stage by Dr Eastgate that this child had been abused by Professor X.

We submit that this evidence is relevant not only to your consideration on head of charge 4, but also to your consideration on head of charge 6; so we would ask you to have this evidence in mind when you consider head of charge 6, the referral.

H You will see there that we have set out in bullet points each of the examples which show the clear and, we submit, unequivocal view being formed at an early stage that abuse had taken place. You will see that there are a large number of examples; a file

A note on 11 July; the nursing note on 11 July; the nursing note for 12 July regarding abuse and the duty to report it to the social services and the police; then the evidence about the 98 per cent certain; the evidence relating to 15 July - although there is reference there to alleged abuse, which is why the defence put that document in, it goes on to state that there was an importance in placing responsibility where it belongs, which perhaps puts rather a different emphasis - then 15 July file note, reference to her concerns that Dr Eastgate should believe her if the matter did not proceed to criminal charges; 16 July, reference to any abuse; the letter that was written by her given to Dr Eastgate on 16 July, which, when you look at it, you may think is a powerful example of how this child did now regard herself as a victim of abuse - that letter, we say, indicates the consequences of exactly what happened on 9 July and the dangers of it; she now did regard herself as an abused child - and the letter to the parents dated 22 July but dictated on the 19th, which states unequivocally to the parents

C “... as with so many young people who have been abused”.

Indeed, when you are considering the evidence relating to head of charge 4, we would submit that the evidence you have just heard from Dr Eyre was important. You may have felt that he was extremely uncomfortable when being asked questions about that session on 9 July.

D Although, of course, we do not have the transcript yet of his evidence, the clear impression you may have gained from his evidence was that he did not regard that note as appropriate or adequate in the circumstances. He was also very uncomfortable when being asked about the last sentence and the potential impact of that on the child, as influencing the child.

E I shall seek to draw distinctions between his approach, his evidence in this case, which we say was clearly delivered with some degree of discomfort, and the rather more assertive and, we would suggest, biased evidence of the two experts you heard on Friday. I will deal with that later.

F Head of charge 5 - this is the record-keeping head - we have highlighted at the beginning of this passage the literature on this topic. We submit that the evidence here discloses a cavalier attitude to note-taking on the dates pleaded in the heads of charge. We say that advisedly because we submit that when you look at some of these notes, they are wholly inadequate.

G In-chief, Dr Eastgate said these notes were private notes for him. They were not dictated for wider consumption and they do not make much sense out of context. That is a quote from him, the reference for which is in the skeleton.

H We submit that that wholly ignores the requirement for verbatim notes so that an accurate assessment of spontaneity could be made later to help with the assessment and treatment of the child later. Furthermore, at that point he could have no idea if these notes of first disclosure, that crucially important period of first disclosure, would be needed in legal proceedings later. Then, of course, there is the point concerning her treatment whilst he was on holiday where, particularly as things appeared to have blown up, if I can use the vernacular, whilst he was on holiday, you may think that

A having accurate notes of first disclosure, firstly, about Professor X and then possibly concerning Mr A, would be extremely important.

Head of charge 5(a) specifically, that relates to the second session on 9 July. Professor Zeitlin says that even if the first session on 9 July was general enough not to require, as an imperative, detailed notes (although he says one should have kept them) it is

B “difficult to understand why, when it is absolutely clear that there is an issue of abuse, there was still no verbatim account [for the second session] ... by then he”,

that is Dr Eastgate,

C “was concerned that something inappropriate had happened.”

Dr Eastgate himself had said that the note for the first session on 9 July was full because of its content. The content of the second session was at least as important and arguably significantly more important. The nursing notes indicate two long sessions for 9 July, but the note for the second session is merely five lines and three words long.

D May I ask you to insert some references from Dr Hall here, please? You may wish to look at day 5/18D, day 5/19E and also day 5/23D, which we say is an important passage, where she says:

“I think the big thing”, those are her words, “that one could criticise him for is”

E the failure to do a full note of the second session. Initially, she said, Dr Eastgate would have to say it sounded wrong because it is important to believe the child. That is day 5/20D and E. But then in cross-examination, she clarified that - this is an example of perhaps inconsistency of her evidence - and conceded:

“He would have had a choice not to say it”,

F but she went on to justify it, or try to justify it, by referring to him being “burdened”. We submit that it is wholly unimpressive evidence on this particular topic. That is day 5/39C and D. Of course, you may think that is more relevant to head of charge 4, but it is relevant, we submit, highly important evidence that you should check by looking at the reference and consider when looking at those two heads.

G Heads of charge 5(b), (c) and (d), this, of course, relates to the period between 9 July disclosure and the referral. Dr Eastgate accepts that it is possible that the note for the second session on 9 July was not dictated until 11 July. That period, of course, covered perhaps the most important period in relation to the Professor X allegations.

H In relation to 10 and 11 July, which are specific heads of charge that you need to consider separately, they do not include the alleged important assertion by Miss A before the referral that her parents would not believe her. The only evidence of this is

A Dr Eastgate's evidence to the Committee at day 4/A to F. Similarly, there is no evidence of the matters set out in the letter of explanation dated May 1999 which you have in your C1 documentation.

If those matters were said by Miss A to Dr Eastgate, it is submitted they are examples of important omissions in the notes and, therefore, highly relevant to your considerations on the heads of charge concerning those specific dates.

B There is reference in the file note of 16 July, as you will be aware, to the fact that verbatim notes should be made and no leading questions should be made. Unsurprisingly, Dr Eastgate says that was not the first he knew of the requirement. There is no evidence that he himself complied with it. If one looks at the period around that time, head of charge 5(e) is the note for 15 July. That is a specific head of charge.

C When you look at that file note, what we would highlight about it is that it makes reference to Miss A asking and then

“one or two specific questions including”,

D and we underline “including”,

“concerns about whether Dr Eastgate would still believe her if the matters proceed to criminal charges.”

E It is submitted that there should have been a verbatim note of all the questions she was asking at this important time. It is not sufficient to say that she asked a number of questions which seemed to be directly relevant to these matters, and then simply say “including” and cite one of them.

Head of charge 5(f) is the file note for 16 July. Again, we highlight a specific passage, but we do not restrict our submissions to this particular passage. The passage records the session as follows. Miss A

F “suggested without any specific clarification that there is rather more to the abuse than she has described, and that it is possible in other relationships with men she has felt uncomfortable, although again I have no specific information regarding this”.

It is submitted that this is an example of a passage in the session that should have been recorded verbatim for obvious reasons, looking at the context of it.

G Head of charge 5(g) relates to 19 July. I am sure I do not need to set out the criticisms in relation to that head of charge. I have set them out briefly in paragraph 5.8. What you may think is important is that, quite apart from the evidence itself, Dr Eastgate himself accepted that that note “could be rather better than it is”, and “it is unhelpful, I have to agree”. There are two passages there we say go straight to the heart of that particular head of charge.

H

A In relation to head of charge 5 in general, paragraph 5.9, when asked about the notes generally for the period from 9 July Dr Eastgate said:

“The notes are very brief, as you are saying. I would not hold them up as an example of good note-taking. I do not believe they are.”

B Of course, when you are looking at this, you may well take into account the fact that there appear to be no file notes at all from a consultant or an SHO or specialist registrar for the whole holiday period, including the period when further allegations were made.

Head of charge 6 ---

C THE LEGAL ASSESSOR: Before you go on to head of charge 6, Miss Glynn, I wonder whether I might just inquire? First of all, it is a matter of detail, but I might just mention it, 5.7 in your skeleton argument, I know how these documents are prepared and how easily a “not” can creep in or out. The passage quoted is “one or two specific questions including”, and then it is summarised as “concerns about whether Dr Eastgate would still believe her if the matters proceed to criminal charges”. I think she was, in fact, asking would he believe her if it did not proceed to criminal charges.

D MISS GLYNN: You are quite right, yes.

THE LEGAL ASSESSOR: But that is a matter of detail. Taking 5 as a whole, it begins on the notice at the moment:

E “You failed to keep a verbatim account of your interviews with Miss A on” various dates. Somebody mentioned this before, but I do not know what conclusion, if any, was reached about it, that the word “verbatim” seems possibly to have been used in different senses from time to time in the course of the hearing.

F MISS GLYNN: I was going to go on to deal with this, if I may, because you will note that there is no suggestion of contemporaneity being required in that head of charge. Of course, it is open to the Committee to make clear what their findings are. What we have suggested is that it was appropriate there should be verbatim notes whenever made and clearly as soon as possible. It is not suggested necessarily that they should have been made during the course of the session, but clearly immediately after, we suggest, would have been appropriate.

G That would appear to be the evidence, although Professor Zeitlin saw no reason why there should not be contemporaneous verbatim notes made. But it is open to the Committee to make a finding in their own terms on that matter. If they wish to clarify what it is they do find, then, of course, that is open to them.

H THE LEGAL ASSESSOR: Yes. In due course, I shall advise the Committee, of course, that they can make a finding in their own terms as long as they do not try to find something more serious against the doctor than is actually alleged. But

A concerning the word “verbatim” specifically, I have not actually been to the dictionary and looked it up, but I think it might mean “word for word accurate”.

MISS GLYNN: Yes, in quotation marks.

MR TURNER: Sir, I have actually the dictionary extract that I will be producing in due course which does say that.

B THE LEGAL ASSESSOR: If it does, then it may be that Mr Turner is going to go on and say that it is, in fact, impossible for anybody ever to produce a literally verbatim record unless the interview is actually tape-recorded, because if you do it in the course of the session you cannot write fast enough, or you might interfere with the therapeutic purpose in any event, or if you make the note afterwards, nobody’s memory could ever be so super humanly good as to remember every single word that was spoken in the course of the interview. So it might be, for example, might it not, that the Committee would have to consider whether the failing was not so much to keep a verbatim account as to keep an adequate account, or something of that account.

MISS GLYNN: Or near verbatim.

THE LEGAL ASSESSOR: Yes. Thank you very much.

D MISS GLYNN: Moving to head of charge 6, if I may, which is the referral head, in my submission, literature is important here. We have set out what we suggest are the important passages, starting off with Cleveland, where of course there is reference to

E “practical issues need to be recognised and resolved at local level in careful discussion between the respective agencies, e.g. what the level of suspicion of physical or sexual abuse should be before the police are informed that an offence appears to have been committed”.

Then, perhaps even more importantly, the passage in Cleveland at page 261, which makes it quite clear that there are a number of circumstances in which it would not be appropriate to refer the matter to outside agencies and different options that are available to the medical practitioner; and that it is only if

F “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”,

G which, of course, brings us on to what is in The Wiltshire Guidance, which I will not quote in full. I am sure the Committee is well familiar with this now. It is at tab 7 of the literature bundle. But the important passages there are, in my submission, the reference to the word “belief” which has been lifted out of the GMC Guidance; the reference to the possibility of a doctor making a referral being required to justify it and the reference to the requirement that such referrals should be based “on sound clinical evaluation and judgment” in which case there can be no criticism.

H

A We have also set out Working Together, the addendum at page 3 where there is the clear reference to the requirement for a “critical threshold” to have been reached before the initial concerns are shared with non-medical colleagues.

B Those are the relevant guidelines in which we say the passage that is relied so extensively on by the defence should be read, because the passage at paragraph 6.2 is the passage that is relied on by Mr Turner throughout the course of his cross-examination, which is the HMSO document, tab 3, page 10, paragraph 9.1.

He has relied on that for some support for the suggestion that once any doctor suspects that child sexual abuse may have occurred, then he must go on to discuss the matter with outside agencies. I paraphrase, but you have the passage there set out.

C It is submitted that where the circumstances indicate that contacting a social worker will necessarily result in a referral or a report being made to the child protection team, the extract from the HMSO publication must be read in the light of the passages cited in paragraph 6.1 above.

D Those are the passages we have just looked at from Cleveland and The Wiltshire Guidelines and Working Together. The decision to speak to the social worker must be based on sound clinical judgment and evaluation and must only be done once the critical threshold has been reached.

We have cited some examples of situations in which a suspicion exists, but it is inappropriate to make a referral, as envisaged in the guidance. There is Professor Zeitlin’s example there of girls with vulval vaginitis.

E A passage from Professor Zeitlin’s evidence at the top of page 10:

“If you do it in all cases where you might consider abuse you will do harm ... the question is how rapidly steps should be taken to protect the child”,

reference to a “safe environment”, the fact that the last event was 11 months before;

F “reasonable grounds to consider other causes” in this case, “therefore it was reasonable to take steps to verify before setting in train events involving child protection.”

It is undisputed evidence here that verification is not the same as investigation. Every witness has conceded that point. Was this seeking informal advice, as has been suggested by Dr Eastgate, or was it reporting or referring the matter?

G We have set out a number of points in paragraph 6.4, which we say clearly indicate that this was a report to Mr Evans. It was not seeking informal advice. We have heard from a witness this morning that Dr Eastgate was somebody who spoke his mind. He was not somebody who is particularly uncertain or tentative. He formed views and he spoke his mind. That evidence, you may think, is important when you consider what was really happening when he spoke to Mr Evans, the social worker.

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A The evidence indicates, first of all, that it was inevitable in the circumstances that Mr Evans would refer and Dr Eastgate knew that. There is a reference there from Dr Eastgate's evidence in which he said:

“One does not necessarily have informal talks with social workers if they feel that what you are telling them is something that is a formal matter.”

B Of course, this was a formal matter. It was a consultant psychiatrist telling a social worker that there had been a report of what could only be described as sexual abuse by a child against a senior medic.

It was hardly likely in the circumstances that the social worker was going to say, “All right, it would be appropriate not to make a referral here, we can risk not doing anything about it.” This was clearly a case for a report.

C The nursing note for 12 July refers to Dr Eastgate's duty to report Miss A's disclosure of abuse to the police and social services. I submit that is important as an indicator of what was really going on on 12 July.

D There is then Dr Eastgate's reference to being 98 per cent certain in the conversation with Mrs A, the speed with which the strategy meeting was arranged, which we suggest is consistent with Dr Eastgate expressing his views to Mr Evans unequivocally. Furthermore, there is no evidence that he told Mrs A that he had sought informal advice. If you look at Mrs A's evidence about this she said: “He told me he was 98 per cent certain that it was criminal and that she” – that must be an error – “had called the police and the child protection unit of the social services ... he said he had contacted the police and social services.”

E Had the critical threshold been reached? This is his evidence about the index of suspicion, paragraph 6.5. We set out here the circumstances that we say were relevant when the sound clinical evaluation and judgment was being made. It is in these circumstances that you, the Committee, we suggest have to look at whether or not this decision was made on the basis of a sound clinical evaluation and judgment: unhappy child; she did not like Professor X and other doctors, male and female; knew about Tanner staging; just the sort of procedure that is open to misinterpretation; knew that the mother and grandmother had accompanied the child on every occasion; knew Professor X was a respected endocrinologist; knew that she did not want to attract his disapproval and was emotionally needy; knew that children frequently make false allegations, not maliciously – 25 per cent through misinterpretation although Dr Eastgate said he thought the incidence was rather lower; no immediate danger to Miss A.

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G We have made reference in paragraph 6.6 to the letter of explanation. Dr Eastgate said that during the period between 9 and 12 July he asked Miss A about some details and she described the layout of the examination room. Dr Eastgate told the Committee he gave those details to the strategy meeting on 16 July but there is no note of that meeting; he relied on his memory, he said. If those details were given to him before the referral they cannot, we submit, amount to appropriate verification because they depend on the statements of Miss A herself. It turns out that the description of the consulting room is not consistent with the diagrams produced by  
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A Professor X or Mrs A to the Committee. Had he spoken to Mrs A before the referral to gather information, as he had done earlier (she is described as an informant) he would have established that fact.

We move on to the second part of Head of Charge 6, the referral without discussing it with the parents. We also submit that that is cavalier in its approach.

B Professor Zeitlin said this was an error of judgment and against written guidelines of good practice. He went on to say there is a clear and unequivocal mandate to consult and take the parents with you at every step. He said he could not see a reason to make the judgment to go against the guidelines: They are quite clear —the parents should be involved at every stage unless there is reason to do otherwise. “I do not know what the reasons were to avoid that extremely important step were.

C The theme of involving parents throughout is to be found in the guidance, and the passages are set out in paragraph 6.9. There is no suggestion that guidelines requiring parental involvement are only relevant to period after referral.

At paragraph 6.10 we have set out a number of points that may be raised by the defence. Dr Eastgate was clearly not dependent on advice about this from Mr Evans because he ignored it. Mr Evans told him that the parents should not be told until after the strategy meeting. We know the strategy meeting was on the 16 July and the parents were told on the afternoon or evening of 12 July.

D The second point, neither could it have been feared that the parents would do something that might jeopardise an investigation because they were told on 12 July, so that necessarily means that Dr Eastgate could not have been concerned about them doing something jeopardise the investigation because they were told four days before the strategy meeting.

E Dr Eastgate agreed that there was no reason to suspect either parent or any other member of the family of behaving improperly towards Miss A. That again is not a reason for not contacting them. Neither can it have been because Miss A had said her parents would not believe her, and he was concerned about the adverse consequences of that to Miss A because, again, he told Mrs A on 12 July in the presence of Miss A, so that again goes to that point. All three of those points, I am afraid, do not work, sir, in relation to this case because of the fact of the disclosure to the mother on 12 July.

F At 6.11. There are numerous references to Mrs A’s worry and concern about her daughter. Dr Eastgate agreed that Mrs A was co-operating, so there was no reason of that sort. If you look through the notes of this case, Mrs A’s concern, worry and appropriate behaviour in relation to the terrible events that were unfolding in this family are set out.

G In this case we submit there were positive reasons to confer with the other as an informant as part of the verification exercise.

H Paragraph 6.13: There are recognised in the Wiltshire guidelines where there is a requirement that a referral must be based on “sound clinical evaluation and judgement” that there are potential adverse consequences. Of course that also can be

A implied by looking at the requirement to justify such a referral set out there and the requirement to reach a critical threshold.

B Mrs A's evidence concerning the concerns of both parents conveyed to Dr Eastgate in a telephone call from her husband on 14 July identifies the possible adverse consequences of a referral. That evidence is set out at Day 1, page 72 D to G. She felt that it would be harmful to Miss A to have the matter hanging over her. She recognised, as, indeed, did her husband, that cases take a long time to be investigated and, if appropriate, tried where the allegations were not made at the time, are uncorroborated, and come from a very disturbed child there is little likelihood of a conviction. The top priority, as far as she was concerned, and the rest of the family was concerned, was to ensure that Miss A got better. Indeed, Dr Eastgate agreed that Mrs A's views were reasonable.

C Professor Zeitlin stated that there was a risk of increasing the division between parent and child, and that it is important for the child to feel that there is support and help from the parents, and that there is a risk of creating a rift between the child, the clinicians and the parents, and precipitate action can cause lasting damage.

D He went on to state – and he stated this on several occasions during his evidence – that there were very considerable consequences because following the referral you have a number of people referring to “abuse by medic”, in other words, confirmation in this child's mind that she was a victim of abuse.

E I move on to the defence expert evidence in this case. When considering alleged inappropriate or unprofessional conduct or failures of record keeping the Committee will need to consider whether Dr Eastgate acted in accordance with practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question. He called two experts to assert that he did. It is the complainant's case that both could be shown to be demonstrably biased in favour of Dr Eastgate and that the Committee should rely instead on the evidence of Professor Zeitlin. We do not make that assertion lightly, sir. We ask you to consider very carefully and rather unusually for a case like this, the evidence of the two experts called by the defence here, and consider very carefully whether you can rely on them as objective experts.

F This is an unusual case in that it is a case with a very considerable history and background that it is has not been relevant to explore in any detail, but, clearly, you may think the impression you have gained is that it raises or has raised strong emotions. Whatever the background is we submit that it is the evidence delivered by these experts themselves that is the clearest indication of lack of objectivity.

G When one looks at the evidence of Dr Hall we submit that at every opportunity she gave evidence as an apologist for Dr Eastgate. She used expressions such as “the shock” that he must have experienced when this child made these disclosures. This we would submit is rather akin to comparing a surgeon working in A&E or a doctor working in A&E being shocked by the sight of blood following an accident. It was a quite extraordinary assertion we submit when we are dealing with a consultant psychiatrist who is regularly dealing with allegations of child sexual abuse being made by his patients to suggest that it is an excuse for poor record keeping or poor

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A interviewing techniques to say that he must have been shocked, or, indeed, burdened by what had happened.

She conceded, as, indeed, did all the other witnesses, that this was not at this stage, an abnormally complex case. We would submit that, far from being abnormally complex, it was a bread and butter case at this stage of a child making an unexpected disclosure of sexual abuse, and therefore when you look at the objectivity of this witness and the evidence she gave we would ask you to look at it in that light.

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Paragraph 7 of her report we say is also revealing because it is clear that she felt it appropriate to make in that passage in the report disapproving remarks about the parents. She also expressed surprise that this case had even come before the General Medical Council given the fact that there had been no allegations against Professor X.

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We submit if you read through paragraph 7 of Dr Hall's report you will get the clearest flavour of lack of objectivity in the approach that she has taken, and when you combine that with the somewhat surprising evidence she gave about a number of aspects of this case, you should rely on Professor Zeitlin and not on her evidence.

It has to be said, however, that when broad principles were put to her in cross-examination, gleaned from Professor Zeitlin's evidence, she was in agreement with it. So when pressed on the key topics in this case she does appear to have conceded that there were problems. I have already highlighted the evidence in some respects, problems with the note-taking, problems with the session on 9 July and the last sentence that is the subject matter of Head of Charge 4.

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When you look at her evidence, and you may by then have the full transcript, we would submit that she was clearly unduly keen to explain away failings by Dr Eastgate by relying on overwork when Dr Eastgate himself had not relied on that as an excuse for what happened. His case is that in fact there was nothing objectionable in what happened.

E

When one looks at the evidence of Dr Bentovim, he has been involved in this case before. It is quite clear from the evidence he gave that he was involved with long and perhaps bitter care proceedings in which he gave evidence on behalf of the Guardian ad litem which was in conflict with the evidence of the parents. It was suggested to him in terms that he was biased and we would submit that it is really the content of his evidence that shows the degree of his bias.

F

One needs, in my submission, to compare the approach that he took, the way he gave his evidence on Friday, with the evidence that you heard from Dr Eyre this morning, which we say was clearly thoughtful and neutral. There was nothing neutral in the way Dr Bentovim delivered his evidence we submit, and particularly in its content. He clearly showed an inability to concede that the complainant's points, that are most clearly and well made out in this case, were, indeed, clearly and well made out. For example, the complaints about the note for the second session of 9 July, he failed to concede that there was anything wrong with that note, and the Committee may have taken the view that it is quite clear that that note is wholly inadequate, but he failed to concede that.

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- A He had great trouble, you may think, in dealing with the evidence concerning the letter of 19 July to Mel Smith. When you have the transcript of his evidence, I would submit that it is important to look at that passage when you are considering his objectivity because he simply failed to deal with that, we submit. He tried as best he could to provide excuses and justifications for it when you may think there were simply none on the evidence available.
- B He in fact in relation to that letter of 19 July described it as “shorthand”, and therefore not nearly as possible verbatim we would submit, but he nevertheless refused to accept it was inadequate and even went so far as to describe it as “very helpful in tracking what Miss A had said.” You may think, and I hope I do not descend into hyperbole here, that that is simply unsustainable and, we would submit, absurd.
- C THE LEGAL ASSESSOR: It might be helpful to the Committee if you or Mr Hurst has been able to identify the references in the transcript.
- MISS GLYNN: I am afraid we have not, because we did not have it in time to do that.
- THE LEGAL ASSESSOR: Well you must be right, I am sorry.
- D MISS GLYNN: He considered that dictating notes in a therapeutic context two days later was “quite unexceptional”, and when he was asked questions about the fact that it was clear that Miss A was safe at the time the referral was made, he even refused to concede that she was safe, raising issues about what goes on in inpatient units and so on, and that there is some debate about that.
- E When asked about suggestibility in the context of the second session on 9 July, he stated that younger children (four/five/six I suppose) are suggestible but that a highly intelligent teenager would be less suggestible and therefore less susceptible to leading and being influenced by the interviewer.
- F We again submit that that has clearly got to be wrong. It ignores that adults can be extremely suggestible, and that this patient was a very ill 13 year old. She was not eating. She was described as being curled up on the floor much of the time. She was self-harming, deeply miserable and keen not to attract Dr Eastgate’s disapproval. How can this witness being objective, as an expert witness is meant to be, suggest that she was not susceptible to leading questions or influence in those circumstances.
- G Sir, we submit that that is the context in which you may seek to look at the evidence of the defence experts when you look in contrast at Professor Zeitlin. Before I return to my skeleton, Mr Hurst has helpfully handed me a note, the reference to “shorthand” in Dr Bentovim’s evidence – I think this transcript was handed to us just before we started this morning so I have not got detailed notes about it – is Day 5, page 89 at B, and the reference to “very helpful” and “tracking” is Day 5, page 88 A to C. When one looks at that evidence of the defence experts we would ---
- H THE CHAIRMAN: The Committee I think have to received, unless they have got them on their desks, the afternoon proceedings transcript, and it would be helpful if they could have them.

- A MISS GLYNN: I think it came round as I got to my feet to address you, sir, literally as I was starting my closing submissions.
- THE CHAIRMAN: I was looking at you and not at my desk, so if we have all got them, that is very helpful, but we have not had a chance to look at it.
- B MISS GLYNN: Nor have I, sir, I am afraid.
- C Sir, when comparing the evidence of the defence experts Hall and Bentovim we would ask you to consider very carefully what you know about Professor Zeitlin. In contrast, we would submit there is no evidence whatsoever of any bias on the part of Professor Zeitlin. In fact he made it apparent on a number of occasions that he was not setting out to criticise Dr Eastgate, and you may have formed the view that he found it unpleasant to have to do so. He was clearly conscious, as he told the Committee on a number of occasions, that the errors which he was describing were actually serious ones, and he was conscious that it has led to this doctor coming before the General Medical Council, so he was very much aware of the responsibility he bears to provide to provide objective expert evidence – emphasising, as he did, he was not nit picking, to use the vernacular, or providing counsel of perfection, and emphasising that this was not an abnormally difficult case for a consultant psychiatrist to handle.
- D No prior connection with either party, unlike Dr Bentovim, who had been partly responsible for training this doctor, Dr Eastgate, and the expression of no views one way or the other, you may think, about any of the background or indeed what followed from the period that you are concerned with between 9 and 19 July.
- E Sir, those are my submissions to you, unless I can assist on any particular point.
- THE CHAIRMAN: Thank you very much, Miss Glynn. You and Mr Hurst have set a very high standard.
- MISS GLYNN: Thank you.
- F THE CHAIRMAN: Mr Turner?
- MR TURNER: Sir, I have also prepared a written document, and perhaps that could be distributed, please.
- THE CHAIRMAN: This will be D13. (Document handed and so marked).
- G MR TURNER: Sir, you will note firstly that my document is very much more narrative in its style than Miss Glynn's document. I have done that so that the Committee can then follow precisely what I am saying, and if the guillotine should come down on me at any stage, then the Committee has the advantage of taking away the document and reflecting on it at leisure.
- H THE CHAIRMAN: I do not think that the Committee are at the moment setting you a time limit.

A MR TURNER: No, I can well understand that. I make it clear that I do not feel under pressure of time, and I am not suggesting for a moment that any improper pressure has been put on me.

B It is also noticeable that my document is longer than Miss Glynn's. It may not appear so on the face of it, but in fact both sides of the pages are printed, so in fact it is exactly twice as long as Miss Glynn's, as well as being narrative in style. I do console myself with the thought, however, that even so it is not as long as a single one of the transcripts of the expert witnesses in this case, who were all a remarkably fluent and opinionated bunch. Indeed it may have come as something of a relief to have the calm, reflective manner of Dr Eastgate when he gave his evidence in a fairly succinct style.

C However, I did not have the opportunity, because of the way the procedure works, to open this case, so Miss Glynn has already had an hour or an hour-and-a half or so to open, to explain her case. What I seek to do for the first time is to pull the strings together for the whole of my case and set it out for you.

D As far as the structure is concerned I have started – and you will see there are sub-headings – with some introductory words and some preliminary general points to be taken into account. What I have then done is move to address the factual allegations in each of the individual heads. I have then gone on to make some short general remarks in relation to the heads; and I have then finally turned to consider again very briefly the question of whether any facts found to be proved can at this stage amount to serious professional misconduct.

E The problem that I face is that over the five and a bit days of evidence that we have had, there are a thousand and one potential points that could be made, and I could not conceivably hope to even spot, let alone address the Committee, on all of them. The Committee has the advantage of having heard the case and having transcripts of the evidence; so please, if there is a point that I do not deal with, do not assume that I am skipping over it because it is an unanswerable point against my client.

F It has been said that it was not for Dr Eastgate, as an experienced consultant child and adolescent psychiatrist, an unusual or particularly complex case to manage – the case of Miss A. That may be so, but one still has to bear in mind the evidence that all of these cases of disturbed children, whether or not there are allegations of child sex abuse, but particularly if there are allegations of child sex abuse, are going to raise a host of difficult and sensitive matters on which individual judgement has to be exercised when dealing with them. We can go through and ask ourselves all of the problems: How do I approach this girl? How do I talk to her? What is her age? G What is her level of understanding? What form of questions should I ask? If something is said by her to me, how should I react? – all things that have to be done on the hoof, as it were, in the heat of battle, on the spur of the moment, not in the calm light of academia but there at the coal face – I am sorry, I am mixing my metaphors and analogies wildly, I know.

H One must, rather than try to look at the case, I suggest, in the sort of nit-picky way, look at it in the round, look at the general management of the case, because it is very

A difficult for someone in Dr Eastgate's position to explain – or indeed the experts who appear on his behalf – to a Committee who has never worked in this particular field of expertise, and which it takes a lifetime to acquire – and it is a constantly developing field, as we have heard – precisely how such problems are always dealt with when they arise. We know that there are immense problems and continue to be immense problems in the management of these cases. The Cleveland inquiry spent months analysing them, made certain recommendations, left certain matters open for further consideration, but every day in the family courts up and down the country there are debates about the very sorts of issues that arise in this case. How did the disclosure come about? Were inappropriate questions asked? Can one verify all of those matters? So indeed they are common points, but it does not make them any easier to deal with, the fact that they are not particularly complex and unusual cases of their sort.

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C So moving to my written presentation, it is, I suggest, important first of all to bear in mind certain things that this hearing is not about. I say that for the benefit of the public and the press as much as anything else, because from reading reports of the case one might be labouring under misapprehensions as to what it is about. It is not about the question of whether anyone – and if so, who – sexually abused Miss A. It is not, therefore, about any question of whether any allegations made by Miss A were in fact false. That issue was at one stage before the High Court. It was never determined by the High Court.

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E If I can just at this point correct one statement which Miss Glynn made towards the end of her address, she said that Dr Bentovim had given evidence for the Guardian *ad litem* against the parents. If by “giving evidence” she means he had made a report, which the parents did not find acceptable, then that is right; but, as we have heard, the matter never actually came to court on a contested basis. The issues have been raised but it was not necessary to deal with them; it was possible to deal with the case on a compromise basis. So there was no oral evidence of the parents or of Dr Bentovim that was ever resolved.

F That of course is raised in the context of the issue of bias. It is a very serious allegation to make against eminent clinicians and experts such as Dr Hall and Dr Bentovim – suggestions of bias. I grant you that both Dr Hall and Dr Bentovim were very vocal, very opinionated, very keen to say much more about the matter and to explain much more about it to the Committee; but I suggest that does not demonstrate bias on their part. What it demonstrates is a concern that the Committee should not misunderstand what life is like in the real world in this particular area of expertise.

G They were not acting as apologists for Dr Eastgate; they were acting as experts to put the other side of the coin, to set out the other end of that spectrum of perfectly permissible professional opinion as to what is and what is not acceptable as things stand, or as they stood in 1996, in the management of cases such as the case of Miss A.

H Moving back to my ‘what the case is not about’, the case is not about the question of whether Dr Eastgate did actually induce Miss A to make false allegations. We do not know whether the allegations she made were false or not, so we do not know whether

A false allegations were induced. It is certainly suggested that he dealt with the sessions in a way that carried that risk; but that is the highest that it is put.

The case is also not about the very vexed and very different question of recovered memory therapy – and we have probably all read in the press or in the professional journals about these sorts of things, usually with adults, where one goes back to their childhood and tries to draw out things that they did not know had ever existed. It is not about that situation at all; it is about, as Miss Glynn has said, a bread-and-butter case that confronted this doctor in the course of his ordinary practice, where he had a disturbed child and he as the clinician needed to try and get to the bottom of what, if any, cause or ascertainable cause there was for her disturbance, so that he could try to remove that as a problem for the future, or to address it with her in his therapeutic work with her and for her benefit.

C There can be no doubt, I submit, that Dr Eastgate is a dedicated clinician. He is not a man who is out on a crusade of some sort to prove sex abuse lurking under any disturbance – although that was suggested to him at one stage, there is, I submit, absolutely no evidence whatsoever to justify that.

D Importantly – and I am looking at paragraph 2 of my presentation – it is not alleged against Dr Eastgate that any conduct on his part led to the making of allegations by Miss A against her father, let alone false allegations against her father. I say that and emphasise it because the opening statement made by Miss Glynn might have led the Committee members to conclude otherwise. The case could – and I submit should – have been opened to the Committee on the absolutely simple, accurate, factual basis that allegations against Professor X were referred to the child protection team; that such investigations as were carried out by the child protection team did not lead to any proceedings and have not even led to Professor X himself being questioned about them. But for some reason the case was opened before the Committee by highlighting the fact, as part of the background history, that there were subsequent allegations made by Miss A against primarily her father, and it was said – and I use the words that one can find in the transcript – that this “pulled the family asunder” for years, and that the session on 9 July 1996 “was the seed from which other allegations made by Miss A started to grow”; and I set out there the reference to that.

F One wonders what the purpose was of drawing to the attention of the Committee those matters that were, as is now conceded, irrelevant to the actual allegations pursued. Of course it is only those matters that are pursued that can properly be explored by those who represent Dr Eastgate. We know that if any further matters had been pursued about the further allegations made by Miss A, there was that mass of evidence, expert and otherwise, that was available for the High Court if the High Court had felt it appropriate and necessary to deal with the matter.

G The danger of such a presentation as the Committee had in opening this case is that it will subconsciously influence the listener – and the Committee may be starting to see the analogy that I was making. As the psychiatric experts told us – and Miss Glynn has just referred to it again – adults as well as children can be susceptible to influences. We can all subconsciously if not consciously be susceptible to influences. So it could be said that planting the seeds of that concern in our minds was conduct on the part of Miss Glynn that was inappropriate; it was inappropriate for her to have

A touched on those matters in the way she did because those remarks are capable of distorting the rest of the process by creating an unwarranted prejudice against Dr Eastgate that he has no opportunity to counter, because he is then estopped from going into those matters which are not allegations.

B However, Miss Glynn is an experienced advocate with undoubted ability, and I know for sure the highest of ethical standards, respected – again, as I know – by her peers. And one assumes confidently that she made those unnecessary remarks in absolute good faith with the mere intention of setting out the full background history for the Committee. But had there been any discussion between her and perhaps fellow professionals before she made those remarks in opening, the danger might have been seen, and she might have dealt with it differently.

C So although with the benefit of hindsight and detailed ex post facto analysis it can be seen that there was a better way of presenting the matter, it could not be said that Miss Glynn had behaved in an unprofessional manner, let alone accuse her of serious professional misconduct.

D I raise that point not to try and score a cheap point off Miss Glynn – who I, if I may say so, consider has presented the complainant’s case superbly and with great ability – but the point that I seek to make is to explain further the point that Dr Bentovim was trying to make at the end of his evidence, when he was pressed by Miss Glynn as to whether he was not prepared to criticise Dr Eastgate’s actions or notes in any way – and you will remember he was being pressed about it: “Well, really you are just an apologist, Dr Bentovim. Can’t you even accept now that this particular note was inadequate?” What Dr Bentovim was trying to explain in effect is that just because with the benefit of hindsight and a detailed analytical consideration one might see other ways of dealing with a particular matter – other ways that might well be better, much better, be it the form of questioning of the patient, be it the form of the notes or be it the stage at which reference is made to the child protection scheme, ways in which others and indeed the individual subsequently may see would have been better ways – it does not necessarily follow that the way in which the thing was actually done at the time, in the context in which it was done, was either inappropriate or unprofessional, particularly when seen in context.

F Dr Bentovim, I suggest, was not being evasive; he was not playing with words; he was not demonstrating bias; he was eloquently and thoughtfully explaining what others might describe as real world considerations in relation to the notes. What he was saying is “Yes, I accept for the purposes now that these notes are inadequate; but it does not follow from that that they were inadequate or inappropriate for the purpose that Dr Eastgate perceived himself as creating them for at the time he created them. For that purpose, for his therapeutic background notes, they were perfectly adequate, whether or not they could have been done differently, and whether or not one now accepts “Yes, it would have been very desirable if they had been fuller notes”.

G The trouble is that clinicians, particularly experienced clinicians, tend to simply do things without thinking. They know so well what they are doing. They know an appropriate form of questions, and when they make notes for themselves they perhaps do not as the younger doctor, the doctor who has had the more recent training about the importance of notes – and we know what importance it has become, certainly in

A recent years – they do not necessarily write down things in the same detail. They know they have done it the right way; they assume that others will accept they have done it the right way. They never dream for a moment that those notes are going to come under scrutiny and analysis years down the line.

B That is the real world consideration that I suggest Dr Bentovim was trying to explain when he was accused of being evasive in his answers; and I suggest it is important not to simply take quotations out of the evidence of Dr Bentovim and Dr Hall out of context. The transcripts of their evidence do, I suggest, pay full consideration, and to look at everything they said in the full context, not just pick pieces out and look at the impression that they gave as a whole of the judgement that can properly be made on an expert basis of the actions and omissions of Dr Eastgate. Because what both of them made clear was that in this highly sensitive and continuing developing field of work there is no right way of dealing with any of the difficult problems that Dr Eastgate was presented with at the various stages of managing this case and which we are now considering. There is a broad spectrum of what is acceptable, and whether or not a particular course is best practice, or whether or not the way it is dealt with is the way in which another person might have dealt with it, particularly with the benefit of hindsight.

D That wonderful benefit of hindsight has been mentioned many times now in this case. It is one of the advantages possessed by a subsequent commentator or critic, and the subsequent commentator or critic has the inestimable advantage of being able to see a particular incident in the context of the overall picture as it subsequently developed. So what might at the time, if one took a snapshot on 9 July, one might say “Well, nothing remarkable about the way in which this has been dealt with”, but if you look at the case another three months down the line you might come back and say “Well, I wish I’d dealt with it in a different way, seeing how things turned out”.

E It is, however, I suggest, wholly unfair to judge the appropriateness of a course of action simply by the consequences of that action, let alone to use the consequences as a factor to judge the seriousness of what was done at the time because, as I made clear at an earlier stage of these proceedings, very minor errors can have dramatic and serious consequences, but the seriousness of the consequences cannot properly be seen as making any error, if there be an error, itself more serious.

F What the commentator or critic should properly be doing is, so far as possible, to put himself or herself into the shoes of the person whose actions are under analysis, try to put themselves into the shoes of that person at the time of whatever it is that is being criticised, with the knowledge available at that time and, importantly, in the context of the role then being performed - we will come back to the difference between therapeutic and investigative roles in a moment - because that is the only fair way, I suggest, to make a critical judgment.

G The problem is it is often impossible, in reality, to not only put yourself back in time, but put yourself in someone else’s shoes and try to see how the problem would have faced them at the time, because the disadvantage is, the other side of the coin is, you do not know what the individual patient was like. You do not have the benefit. You have the disadvantage of not being able to see precisely how she reacted to judge for

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A | yourself as at 1996 what her intellectual development was, just how disturbed she was, what the nuances were of the way in which she spoke, moved, reacted.

Those difficulties that I suggest Professor Zeitlin would in any event have had in analysing and forming a critical opinion of Dr Eastgate's actions in July 1996 have been aggravated, considerably aggravated, by the fact that he has had lengthy sessions with both of the parents and, indeed, two sessions, we are told, with Miss A herself.

B | Those sessions that Professor Zeitlin had with the parents and with Miss A were, of course, many years down the line. The Miss A who presented herself to Professor Zeitlin would have been a very different Miss A from the Miss A who was presenting to Dr Eastgate in 1996. Why on earth did Professor Zeitlin think it appropriate to see them for the purpose of commenting on what Dr Eastgate did in 1996?

C | In a sense, one can understand, in the context of this case - context being all important - because it was the parents who were actually instructing Professor Zeitlin in their capacity as the complainants who present the case, not, as would normally be the case, or more usually be the case, by the GMC and by solicitors who conventionally act for the Council.

D | Normally, the Council's solicitors would go off and appoint an expert, if it was thought one was necessary, and discuss with the expert what course the expert should take and consider the appropriateness of various matters. Poor old Professor Zeitlin, in a sense, being instructed by the As had to see them. But the danger is that someone in the position of Professor Zeitlin, whether he likes it or not and whether he asserts he is not susceptible or not, is susceptible to influences. He protested that he has dealt with the matter and criticises it only on the basis of the documentation before him and before the Committee, but if that was his job, why does he need to see Miss A at all?

E | How does he know that he is immune from those susceptibilities that he says all the rest of us, adults and children, have?

The danger is, then, that he comes to form his opinions with the understandably partisan concerns of the parents personally expressed to him with emphasis on the consequences for the family of what happened back there in July 1996, but without the balance that might result if there had at least been an interview with Dr Eastgate as well.

F | I suggest there should not have been an interview with anyone; we do not need to form the sort of judgment that has been formed here, and it has not been necessary to refer to any of the interviews with the parents or with Miss A. However, there is that nagging fear that, to some extent, they may have put Professor Zeitlin's views in a different perspective, in a different context, from the views that he might otherwise have had.

G | I do not accuse him of bias, certainly not conscious bias, but I do criticise the decision to approach the matter in that way. I say that Professor Zeitlin had two lengthy sessions with Miss A herself and, rightly, the Committee has not heard anything about what the girl said, let alone whether Professor Zeitlin used any leading questions or inappropriate techniques when he had his sessions with her.

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A | However, what we do know, because I asked him about it, was whether the topics he discussed with her included whether she, looking back now as an adult, had felt under any pressure to make the allegations she made in 1996. So having discussed that very topic with Miss A, how can one really exclude the possibility that her answers have influenced Professor Zeitlin? It really is disingenuous, I suggest, for him to suggest that he is able to put such matters out of his subconscious as well as conscious mind.

B | In a very real sense, therefore, I suggest that it is Professor Zeitlin who has muddied the waters in this case in just the same way that he has criticised Dr Eastgate for doing by putting us in the position where we cannot be quite sure what has influenced his opinions. How can we exclude the possibility that he has been influenced in that way?

C | As I say, I do not suggest Professor Zeitlin has deliberately acted in bad faith, but I do suggest that a different approach would have been preferable. I come back now to my analogy with the criticisms of Dr Eastgate. With the benefit of hindsight and analytical analysis, it can be seen that Professor Zeitlin's conduct was not appropriate at the time. It is always easy to criticise with the benefit of hindsight, but I do criticise, just as Professor Zeitlin seeks to criticise Dr Eastgate with the benefit of hindsight. There was a better way of doing it. I do not suggest, however, that Professor Zeitlin is guilty of professional misconduct, let alone serious professional misconduct.

D | While I am on Professor Zeitlin, what I also invite the Committee to conclude is that as well as being clearly a skilled psychiatrist and, indeed, perhaps because he is a skilled psychiatrist, Professor Zeitlin is also a skilled and an experienced witness. He may be expected to know full well the subtle influence that remarks that he made of the sort "Well, it gives me no pleasure to make these criticisms" would have on the Committee. He would know full well that sort of remark volunteered by him would serve to place more emphasis on the views that he expressed.

E | Indeed, there were on many occasions one can find in the transcript of his evidence situations where he, I suggest, was acting as much an advocate of the cause he was putting forward as an expert in it. I would ask him a question and he would not directly answer my question. He would give a long answer about a point that he wanted to bring out and would then refer to documentation on matters to which I had not drawn his attention but which he had noticed on a particular page or the page earlier which supported his views.

F | I suggest that those points should be borne in mind to balance, at the very least, against the criticisms that have been put forward by Miss Glynn against the way in which Dr Bentovim and Dr Hall gave their evidence.

G | So, easy with the benefit of hindsight and detailed analysis to point to a different approach that might have received a better result, but I say again, important to bear in mind "real world" considerations, responding in the heat of the moment without the benefit of lengthy reflection and with all the pressures that workload in the real world, the hurly-burly of daily life in the real world, bring.

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- A That relates particularly to the form of questioning, to the detail, or lack of detail, in the notes, and they go to the question of whether particular actions were within the bounds of what is acceptable, not to the question of whether it could have been done better, but whether it is acceptable, bearing in mind that broad spectrum of professional opinion that this Committee has now had the benefit of hearing.
- B For example, I am looking at paragraph 13 of my presentation, as to the form of words Dr Eastgate may have used in his sessions with Miss A: Just as a barrister presenting a case and questioning a witness will not know what answers he is going to get, he may think he is going down a particular path and he may get a very surprising answer and has then to try to deal with it on the hoof. So also a psychiatrist may be going down a particular path and, no matter how skilled and experienced the barrister or the psychiatrist may be, one can sometimes be a little thrown by the results of questions.
- C So if it was the case here that during those sessions on 9 July Dr Eastgate thought he was perhaps getting to a problem that Miss A had, he knew that she had shown antipathy towards Professor X, she had been saying, "Oh, well, there is someone else who I feel let down by" - we see that from the notes of previous occasions - he knew about the antipathy to Professor X, he asked a series of questions by way of process of elimination which brought him to London. He suggested, "Well, if it was not family,
- D it was not various people, perhaps it was a medic?" "Yes."
- E There he is thinking: Well, I know she did not like Professor X - not really surprising because here was this young girl approaching puberty, so she has the embarrassment of going to see someone who examines her state of sexual development, someone who is affecting her state of sexual development, confusing itself for a young girl. Not surprising, therefore, that with wholly proper conduct on the part of Professor X, this young girl would feel disturbed, uncomfortable by what had gone on. Perhaps that is what is at the heart of at least part of her problem. This appears to be the line we are going down. Suddenly, instead of, yes, her discomfort at those sorts of things being revealed wholly unexpectedly, she says that Professor X had actually stroked her breasts, and all the rest. It might throw to some extent the best of psychiatrists.
- F In those circumstances, of course, he has to be careful what he then goes on to say to her, but is it not very, very understandable, with the benefit of hindsight and detailed analysis, one might be able to come up with a better way of responding to what she said than the way in which he did?
- G By saying that, I do not accept for a moment that anything he did say fell outside the bounds of acceptability and proper professional practice, but simply that it may be, with the benefit of hindsight, things could have been done better. So it is essential not to be over-analytical when assessing Dr Eastgate's conduct.
- H Having looked at the benefit of hindsight, there is also, as I say, the disadvantage of the position of hindsight, and that is not having the benefit of knowing the patient at the time, the subtle intricacies of the behaviour, the body language, and whatever, and all the rest of it. Even if there was a good video recording of what goes on, one knows from the Cleveland report that the professionals even argue about video films and what one can say by way of interpretation from video films. There is a whole

A chunk of the Cleveland report where some experts like them, some do not, some say they are misleading, some say they are unhelpful. There is always argument about the proper interpretation of them.

However, what is lacking is the full flavour of the matter as it existed on the ground at the time. That is the important thing. We can never recreate that full flavour against which we are trying to judge this practitioner. So I suggest it is essential that full allowance be made for that when judging him.

I have made mention of events at the relevant time, the relevant time, July 1996. A good deal of water has passed under the bridge since then. It is often said that justice delayed is justice denied. In previous submissions I have made reference to Article 6 of the European Convention and Rule 17(1) of the Rules by which this Committee is governed, both of which emphasise the importance of proceedings being pursued expeditiously.

On any view of things, the present proceedings have not been pursued expeditiously; perhaps another danger of permitting complaints to be prosecuted by complainants rather than the Council - a situation, I understand, which has now come to an end as a matter of fact.

However, one of the dangers of delay, and the reason I mention at this point delay, is that evidence, relevant details and, as important as that, recollections can be lost or distorted. Who knows what additional evidence or recollections might have been available if this matter had been dealt with more promptly? It may be, for all we know, social services' files would have been available that are not available now. Other files that we have had the opportunity to look at will, of course, have been butchered in the meantime because of the care proceedings because we know there has been litigation about this matter, butchered and reorganised. Dr Eastgate's own detailed recollections are simply not as good as they might have been earlier on. Indeed, none of the other witnesses of fact can have such good recollections as they might have had closer to the event.

That creates problems in relation not only to trying to explain one's actions, and it is difficult enough for a practitioner in front of a Committee like this in the short time available of necessity to try to explain, even if one can explain it to oneself, just why one did things at the time. Instinctively, one felt they were right at the time, but to have to explain them in words to a Committee is not easy, particularly years down the line.

For example, the specific example I raise is this 98 per cent certain issue. It is prayed-in-aid a number of times in Miss Glynn's submissions against Dr Eastgate, but was it actually said? If it was said, what was meant by it? Mrs A does not have any contemporaneous record of it. She now says that was her recollection. Professor Eastgate, in a fair and, I hope you may think, reflective way, said, "Of course, I cannot exclude the possibility that I said it." He is not one of those witnesses, "Of course I did not say it. Of course I would never say anything like that." He said, "Well, I do not think I said it. It does not sound like my style, but if I said it, well, perhaps what I meant was this, this and this."

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- A That is the danger. That is another subtle influence on this case, the risk that the Committee may say, well, perhaps he did say it, although the Committee has to be satisfied beyond reasonable doubt. However, that is one of the problems, no contemporaneous record about it.
- B I would suggest that, far from being sure beyond reasonable doubt that he did say that, the Committee may have very real reservations as to whether he did. Does it fit with the reflective, considered, measured approach that not only has Dr Eastgate demonstrated in his evidence to this Committee, but is also spoken of by many of the character witnesses in their testimonials? Those are the sorts of words you have seen.
- C I called Dr Eyre this morning. I deliberately called him as a “warts and all” witness, knowing that there will be things he said that would paint a picture of Dr Eastgate not being entirely calm on all occasions. Like all of us, there have been times when Dr Eastgate has got into a professional dispute with a colleague. Like all of us, there are times when he gets frustrated by bureaucracy and administration. You may think, nevertheless, Dr Eyre has given you a very rounded picture of a rounded, reflective man whose primary concern is his patient.
- D So when looking at the delay I ask that any doubt there is in relation to matters of fact, the benefit of that doubt should be given to Dr Eastgate, not just because that is what the rules require but because that is what fairness requires, particularly where there has been delay of this sort. That delay also raises another point because there is the risk of judging by reference to standards that may not have existed in the same way or to the same degree at the time we are looking at as exist now. In particular the relevant matter I mean there is, of course, the file notes. That is where I acknowledge the defence has the greatest difficulty in this case, the now perceived inadequacies, in the context in which we are looking at them, of those notes that Dr Eastgate kept or it is more appropriate to say did not keep at the time.
- E Have the standards developed since 1996? Are practitioners even more aware and perhaps they should have been aware the? Certainly the medical members of the Committee will have a greater understanding of that than I and will bring their professional expertise to bear on that.
- F The examination of the Heads of Charge: it is important to bear in mind that at this stage of the proceedings, it is no longer of whether the evidence is capable of supporting the factual allegations made in the Heads of Charge, what the Committee now have to decide is whether on consideration of all the evidence that is now available the Committee can be sure that those factual allegations are correct because there is now available a good deal more evidence before the Committee than there was at the time of the previous submissions. There is the evidence from and on behalf of Dr Eastgate so as to put the thing in better and fuller perspective (paragraph 21).
- G There has also been the evidence in support of Mr Evans the senior social worker. Of course that was another advantage that was not available to Professor Zeitlin when he prepared his report to understand what had happened in relation to Mr Evans or that there had been that consultation with Mr Evans before the formal referral had been made, or to have heard the advice and recommendations that Mr Evans says he gave to Dr Eastgate.
- H

A The Committee has had the benefit of the evidence from two further acknowledged experts in the field who looked at in the round by no means support the criticisms of Professor Zeitlin, so there is now available that wide spread of the sort of approaches and views available in this sensitive, emotive and complex field of practice. Both of the defence experts are highly respected in the field, have enormous clinical experience and have enormous experience of critical analysis of the actions of others. They are often appointed as independent experts in the High Court. Clearly, both of them had strong views on the case that they were able to explain and were anxious to explain at even greater length than they did. As I have said already, it is difficult to explain in a short compass the complexities of these matters.

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C So the evidence of those witnesses goes to the question as to whether certain of the actions of Dr Eastgate fall within the broad spectrum of acceptable practice in the field, and if and in so far as it fell below an acceptable standard, the degree of seriousness of that falling below the acceptable standard.

D I suggest it would be very difficult for this Committee to say, "We reject the views and the opinions of those two experts." They are different from, and they place different emphasis on, the matter than does Professor Zeitlin. As you have heard, that is far from unusual in this field. We have seen from the Cleveland report the sort of variety of views that were being expressed before Lady Justice Butler Sloss, the president of the family division now, and her team. There was a wide divergency of views being expressed and it was not said that one was right and one was wrong. To a great extent they are differences in emphasis. The importance is that one has got to make a clinical judgment in an individual case. Does it fall outwith the bounds of that?

E Finally, before we come to the charges (at last) the words "beyond reasonable doubt", because at this stage in the proceedings it is not a question of whether the evidence is capable of supporting the facts alleged but whether the Committee can be sure beyond reasonable doubt that those facts are made out. The facts include the factual allegations such as inappropriate and unprofessional, not just what it is alleged Dr Eastgate did or did not do but whether as a matter of fact such conduct was inappropriate and unprofessional.

F To be satisfied beyond reasonable doubt means, of course, the same as being sure in relation to each relevant issue, so the members of the Committee (and I know, as it were, I am teaching my grandmother to suck eggs here but I say it nevertheless) that on the basis of all the evidence, am I sure that this particular allegation is a fact? Can I properly exclude all other possibilities? If on the basis of the totality of the evidence you are not completely sure one way or the other on any particular allegation of fact then you have a doubt and the practitioner is entitled to the benefit of that doubt. The complainants are the ones who pursue the charge, it is right that the burden is on them to satisfy the Committee to that high standard.

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H Moving at last to the Heads of Charge: Head of Charge 1, not an issue in the case. Head of Charge 2, not an issue in the case. Head of Charge 3 is the head of charge that relates to the first session between Dr Eastgate and Miss A on 9 July 1996. Although the essence of it has been said to be inappropriate leading questions, it is

A | important to bear in mind, I suggest, the precise wording of the particular allegations in deciding which of those allegations, if any of them, are made out.

It is alleged that certain particularised questions, and we see them set out in the heads of charge ---

B | THE CHAIRMAN: (a) (i), (ii) and (iii).

C | MR TURNER: That is right. It is suggested that those particularised questions and comments were, first, inappropriate, and/or unprofessional but before one can turn to the question of whether such comments were inappropriate and/or unprofessional you have to decide whether you can be sure beyond reasonable doubt that such a comment was made. Can you be sure that that specified question was asked or that specified comment was made. I suggest that the problem the complainants face in this regard is that the notes of the relevant session do not purport to be verbatim notes, nor, indeed, do they purport to be any more than an overall summary of what was said during the session.

D | I appreciate that that fact in itself gives rise to Head of Charge 5, and I will deal with that on its own merits in due course, but, nevertheless, it does create this problem for the Committee, how can you be sure and exclude all other possibilities that those precise words and comments were actually made?

E | The charge could have been made in a more general way. It could have been framed in a more general way, but that has not been done so the Committee members I suggest must decide whether they are sure those words were used or whether what is set out in the file notes for that first session on 9 July are simply a synopsis, an abridgement, a trigger of a much more general form of conversation, because we have heard the sort of length of time that the regular sessions would take, something in the order of 50 minutes. There cannot conceivably be anything like a full record of that, and, indeed, it would be very artificial to expect a practitioner to sit down and make a full record, a contemporaneous record or a verbatim record or any sort of full record of a 50 minute consultation with his patient. It is not just a part of the real world that practitioners/clinicians do that, particularly in the psychiatric field, where you are sitting down and having a chat to the patient, trying to draw the patient out, trying to understand what is at the heart of the patient's problems. That is not what therapy is all about, to make detailed notes. What one makes is enough notes to trigger one's own recollection when one comes back to the next session a few more patients down the line to remember where you had got to in your therapeutic process with this particular patient.

F | If, however, the Committee feels sure that the questions, including the particularised words, were in fact used the next issue that arises is whether the use of those questions and comments was inappropriate or unprofessional. But it is only possible to judge, I suggest, that matter by reference to the full context. I mean by that, first of all, the context of the session itself, and, secondly, the context of precisely what the surrounding words were in which any such challenged words were used.

H | The overall context was clearly that of a therapeutic interview of a severely disturbed young lady who had eating problems. She was self-harming. She had written what I

A have put in inverted commas a “suicide note”, which we have had at D1. I would mention in passing the notes she has written, and we have seen two of them, D1 and D2, to give us some impression of the sort of intellectual abilities of this girl. Clearly she was an intelligent girl but she was a reluctant communicator in the spoken word. That is absolutely clear from her mother, from the notes made by previous doctors and from Dr Eastgate’s own records.

B Indeed, the records for 9 July, although Miss Glynn would have us believe that she was much more relaxed and there was no problem in drawing her out at that stage, actually start with the words, “Again [Miss A] very withdrawn and not talking”. That is the very first thing that is recorded in the notes of that session. We know that she had previously expressed antipathy towards Professor X. She had indicated there were things other than those discussed initially in May that were causing problems – and here I have put the references for the assistance of the Committee – “there was something that was bothering her”. There was something holding her back from talking and she wished she could talk. There were various ways in which she felt she had been let down by people and “there was somebody else but she could not tell”, and I have put all the references there in paragraph 31.

D It is against that background that we submit that that first session on 9 July, which would have been lengthy, even construed on the basis of precise questions of the form suggested in the notes, was wholly appropriate and professional. Indeed, it would at the very least have been adequate even if the interview had been a full-blooded Memorandum investigative-type interview, which it was not, but looked at in the context of a therapeutic interview with no reason to suppose there were sexual abuse allegations, certainly at that stage, but every reason to suppose that perhaps one of the problems might be with this treatment that she has had for her growth and bringing on her puberty, can the Committee really be sure beyond reasonable doubt that the form of questioning on that first session was inappropriate? We say even if no account is taken of the opinions of Dr Hall and Dr Bentovim, as a matter of common sense it is clear that the form of questioning and comment there was appropriate, if it appeared exactly as set out there. The purpose of the therapeutic sessions, as I have, is to try and discover the root of the disturbed behaviour so any necessary issues can be addressed appropriate. The need to try to help the patient is the only consideration in the therapeutic session. Of course we accept that it would not help the patient to induce her to make false allegations, so, of course, one does not go in feet first suggesting to the girl, “Well the reason you’re disturbed perhaps is because you’ve been sexually abused”. No clinician of the experience of Dr Eastgate could be expected for one moment to have said such a thing unless it was a complete and utter aberration on his part.

G The interviewer in the therapeutic session, we suggest, is much more justified in using a facilitative technique to draw out the uncommunicative patient than a police officer, social worker or psychiatrist who is conducting a formal video recorded interview for the purpose of evidence being given in expected court proceedings at some stage.

H There was, as Lady Justice Butler Sloss made clear in one of the authorities we looked at, wholly different purposes for the two exercises. So, far from being anything to suggest that sexual abuse was likely as the root cause of the problems of Miss A at the start of that interview on 9 July, and indeed, at the end of that interview far more

A likely as Dr Eastgate he felt and Dr Bentovim and Dr Hall confirmed they would have thought, was that there were problems with Professor X but they were problems arising out of perfectly proper conduct by Professor X given the sensitive circumstance in which he had seen the young lady. The distinction in respect of interview technique, depending on the purpose of interview, has been recognised and endorsed, I suggest, in a number of places. I am not going to ask the Committee to look at them now because I have set out the detailed references, but if we look at those we will see clear endorsement and recognition of differences in forms of questioning, although I do not for a moment suggest that one can go in and use wholly inappropriate questioning, there is rather more scope in the therapeutic facilitative interview with the uncommunicative patient.

Paragraph 35: The record of that first session begins with a reference to Miss A again being withdrawn and not talking, so what would a therapist do? Try to draw her out. According to the notes, Dr Eastgate then reminded her of a previous session when she had indicated she felt let down in various ways and in respect of which she told him there was somebody else but she had not felt able to tell him about it, something about which Dr Eastgate had sensed embarrassment. It cannot be, and is not, suggested that that sort of introductory reminder is in any sense inappropriate, he is just reminding her about what she has said on a past occasion. At this point Miss A is recorded as becoming watery-eyed and withdrawn so Dr Eastgate is entitled, is he not, to justifiably conclude that he is perhaps on the right track given the reaction of the girl to the probing, and justified in trying to discover something more about what she is not telling him. Does he sense that she wants to tell him but needs to have it drawn out? That was one of the suggestions that Dr Bentovim made. He said it often happens that young people will want to tell but do not want to volunteer it, they want to have it drawn out of them.

E The questioning then described in the notes, we suggest, was a wholly appropriate process of elimination in the context of that sort of interview for a young person of 13, intelligent but uncommunicative.

Then we have the final suggestion, the London suggestion. This was a perfectly proper process of elimination, we suggest. The question, is it somebody in London? resulted in silence as opposed to specific negatives in respect of the other possibilities. Of course, anyone would conclude from that (psychiatrist or otherwise) if you have got positive answers in the negative, as it were, to a series of questions and then you run into a silence you are on the right track. Can one really say that in this context, the uncommunicative girl who needs to be drawn out, Dr Eastgate should not in the circumstances of whether it be described as suggested, guessed, wondered, whatever form of words he actually may have used, wondered whether the problem lay with someone in London and communicated that suggestion, yes, speculation to Miss A. What really was wrong with that?

H Is it seriously suggested that by saying that Dr Eastgate was placing in Miss A's mind the idea that someone in London had sexually abused her, or is it seriously to be suggested that she would have agreed with him: "Yes, you're right when you wonder if it was someone in London" simply to try to please him. She had not found any problem saying No before when he had asked her questions, so she was not just set to

A please him come what may. One has got to try and keep a sense of reality when analysing these summary notes of the interview that took place.

If Dr Eastgate had broached the whole topic by simply saying words to the effect of: “I guess it’s someone in London who gives you concern, that person is Professor X”, that might give rise to justifiable criticism, but in context what he was doing was facilitating an uncommunicative young girl who had problems to tell him something and he had no idea at the time it was going to be an allegation of sexual abuse.

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The second paragraph on the second page of the note continues with what is clearly only a summary of the drawing out, but it was someone medical – a matter, by the way, that does not feature in the particulars of the heads of charge as an allegation – and whatever was the cause of distress had happened on a number of occasions. So we look at it in context and we see that the mention of Professor X by Dr Eastgate’s process of elimination is not so surprising. Both Dr Hall and Dr Bentovim said in that context, and given the history and the antipathy towards Professor X, the purpose of a therapeutic interview seems entirely appropriate to enquire whether that was a problem, as Dr Eastgate perceived it might be.

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Can it really be said that by saying that, Dr Eastgate was not only placing in this young lady’s mind that she had some sort of problem with Professor X – which was well known; it was well known to everyone she had a problem with Professor X. That was nothing new – but placing in her mind that that problem was a sexual abuse problem is reading far too much into it, and with the benefit of hindsight, we say.

D

So it was appropriate, we submit, for Dr Eastgate to explore with Miss A when it was she first felt uncomfortable – the whole process of seeing a doctor to inhibit growth would be likely to make any girl of that age feel uncomfortable.

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Can one criticise Dr Eastgate without the benefit of hindsight for not foreseeing that there was a sexual abuse allegation in the offing? It is said that he, as it were, ran the risk of inciting that allegation, which might have been false; but we say realistically that cannot follow, and it cannot have been something that a reasonable practitioner would have had in mind at the time. It is certainly not outside the band of acceptable behaviour. And as we have also heard, first-time disclosures of sex abuse in the course of therapy as an in-patient are in fact rare, so even less likely to be expected. So it is difficult to see how Dr Eastgate ought to have realised that what he was saying was wrong at that time.

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At that point Miss A declines to discuss the matter further – not surprising, perhaps, if she had this feeling of embarrassment, Dr Eastgate thought; but he understandably thought: “We’re really getting somewhere now. I’m getting somewhere. Rather than wait until next week to continue this, I think it’s important I try to push it while she’s being a little more communicative, I’ll try to push it sooner rather than later”. So later on that same day he fitted into his undoubtedly busy schedule a further session. I say “undoubtedly fitted into a busy schedule an additional session” because that may well go some way to explain the paucity of the note in relation to that second session. It was not a session that had been planned and fitted in the scheme of things with his workload anyway; he fitted it in for the benefit of his patient. It was hardly surprising if he did not have much opportunity to write a fuller note at the end of it.

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I say that not by way of excuse but by way of explanation – by way of real world explanation. Yes, of course, as Dr Eastgate was the first to accept, it would be better if it had been a longer note; but what was the purpose of it? I will come back to that in relation to head of charge 5.

B

So in summary in relation to that head of charge 3, the findings that we suggest the Committee should make in that regard are set out in paragraph 39, and I will not read that out.

C

Head of charge 4, that relates to the second session on 9 July. It asserts in effect that Dr Eastgate improperly transmitted his own views to Miss A, with the danger that she might be influenced in an inappropriate manner. But as with the previous head of charge, 3, it is necessary to question first of all whether it is possible to be sure that the actual phrases and words relied upon in the head of charge were actually used. So, again, that is the first problem that the complainants have in relation to that head of charge.

D

The members of the Committee must, I suggest, consider whether they can be sure the phrases relied on were used, and were used in a context – we come back to context again – that would transmit views held by Dr Eastgate to Miss A in a manner that was inappropriate and/or unprofessional.

E

At that point, certainly when the session starts, if Dr Eastgate is to be believed, no thought still that sexual abuse might be at the bottom of all this. It is important to note that there is no allegation against Dr Eastgate that the detailed allegations of breast stroking, et cetera, actually emerged as an answer to leading questions. Miss Glynn would say “Of course I can’t allege that because I haven’t got the transcript of exactly what happened, so we don’t know”, and that is the very complaint about the notes. Of course what I have said is “Well, looking at it from Dr Eastgate’s perspective, these notes were made after the event, no doubt in a rush, squeezed into a moment when he had the opportunity of this extra session, as trigger notes for him to remind him of what had been said, not with a view to court proceedings coming out of this but as some record of what had been said”.

F

So there is no suggestion that that information was the result of leading questions; indeed, I submit, it would be bizarre if as experienced and as reflective a clinician as Dr Eastgate would ever have asked a question that itself suggested a response of the sort “He stroked my breasts”. He would have to ask a very specific question about sexual abuse to get that sort of answer, if it was not spontaneously given by the girl. So one certainly cannot, put at its lowest, exclude the possibility that this was a spontaneous allegation by the girl, rather than one made in response to any sort of leading question.

G

The overwhelming likelihood is then, I suggest, that that information was received by her in response to appropriate questions, no doubt probing with her “Why is it that you felt uncomfortable with Professor X? Tell me about it”. Then out comes the “Oh, well, because he stroked my breasts”. “Well, goodness gracious me!” – one can just see it going through Dr Eastgate’s head – “Now what can I do?”

H

A THE CHAIRMAN: I wonder if we are getting off the charge itself. (i) says “told Miss A that what Professor X had done sounded wrong”; (ii) says “told Miss A that you were worried he may have done it to others as well”, and it just says “your comments related to the above were inappropriate”. We have left the morning and we have got to the afternoon, and I do think it would be very helpful if we could concentrate on the afternoon.

B MR TURNER: Yes, I hope that I was, because in paragraph 43 I hope I do directly address that, because those words have come from what was recorded by Dr Eastgate of course in that note about the second session. He has recorded her saying words to the effect that “Although what she described felt uncomfortable and wrong to her, she didn’t know what doctors were supposed to do and felt she was probably responsible for what happened” – as we have heard from the experts, not an uncommon perspective with a girl who has been sexually abused.

C So it is in that context the notes of the remarks have to be considered. The first of those notes indicates that Dr Eastgate suggested – and I pause there to say “suggested” is a tentative word – whether it is suggested, or whether he, to use his phrase he would normally use, “I wondered whether”, suggested that it sounded wrong to him. The complete quotation: “I suggested that not only did it sound wrong to me, but ...”.

D The wording in head of charge 4(a)(i) actually distorts that phraseology, I suggest, and takes it completely out of context, because what the note does not suggest is that Dr Eastgate told Miss A that Professor X had done anything. All that it records is in effect that he was commenting that if, on the basis of what she had described, it sounded wrong. Not a confirmation that he thought such an act had actually occurred, but reassuring her that it was not just her who would think it wrong, but what she had described did sound wrong – as it did. What on earth is wrong with that? Nothing inappropriate or unprofessional in giving such reassurance. And contrary to what has been asserted, it does not suggest approval of what she had said; it does not suggest acceptance of the truth of what she had said; it is not praise for what she said or for what has been revealed, or encouragement to reveal more. It is simply a factual reassurance that what she has described is something that would be wrong. It is taking what she said seriously – as all the guidance tells us we must do when

E allegations are made; that she should not blame herself – again, all the experts acknowledge that that would be an entirely appropriate response. The only judgement that it implies is the honest and factually accurate judgement that actions of the sort described by her would be wrong. The need to indicate that allegations are taken seriously, to reassure and to be honest with young people, are confirmed in the references that I have set out at the end of paragraph 44.

F

G So it must be borne in mind, a highly intelligent 13-year-old, Dr Hall and Dr Bentovim have both rejected the notion that such a young person would be likely to be influenced by such words, to make further allegations irrespective of the truth. Indeed, they regard the next words complained of, being “I was worried that he may have done it to other children as well”, as words that might give a young person the opportunity to retract the first allegation if it was not true, to say “Well, you’ve made this allegation. What you’ve described sounds wrong. As a matter of fact, I’ve got to

H be worried that this person, if this has happened to you, then it might happen to other

A | people” – laying the ground to tell her, as he would have to do, about the obligations that he might have, giving her the opportunity to recant, to retract the allegations if it was not true, once the seriousness of it was made known to her. What, again we say, is wrong with that?

B | Can it be said that that would impart some sort of approval of what she had said, encouragement to make false allegations of some sort? It is just nonsense, on a common-sense approach.

Even if a different approach, different words, could have been adopted, can it really be said beyond reasonable doubt that that was inappropriate, unprofessional, fell outside the proper and acceptable boundaries of what was appropriate in these circumstances, in this context?

C | In paragraph 46 I set out again the conclusions that we invite the Committee to draw.

D | Head 5. This is the one that alleges that Dr Eastgate failed to keep a verbatim account. In a sense it is the most worrying one for the defence, because it is the criticism that we accept is best founded of Dr Eastgate, that certainly with the benefit of hindsight, if nothing else, his notes should have been fuller. He acknowledged that immediately himself, once it was put to him. But the charge alleges that he failed to keep a verbatim account of his interviews with Miss A in respect of the various meetings that are there particularised. One may have to give separate consideration to each of them in turn, because ‘failure’ is a word that has connotations of something that fell below the proper standards.

E | As a matter of fact, of course, it is agreed that Dr Eastgate did not keep a verbatim account of those specified meetings; but it is not accepted on his behalf that in context – and context is all, again – that that absence of verbatim notes can properly be condemned as a failure – a failure to do something which is a necessity if proper practice is to be followed. We say proper practice does not require as a necessity the keeping of verbatim notes – or did not require the keeping of verbatim notes – in relation to any one of those specified sessions.

F | I go then to ask first whether proper practice necessarily requires a verbatim note to be kept in the context of these interviews – interviews that were for a therapeutic purpose. The meaning of verbatim is, as the Legal Assessor rightly suspected, “word for word”, or “in exact words”. I have put right at the back of my submissions four pages. The first two of these four pages is the frontispiece of the third edition of *The Shorter Oxford English Dictionary* and the page on which ‘verbatim’ is actually defined. The primary meaning of it is indeed “word for word” or “in the exact words”.

G | In reality, therefore I suggest, it would be impossible to keep a verbatim account of the relevant interviews unless the words spoken were recorded during the interviews themselves; and even then it would not be possible to achieve a verbatim note unless the interviews proceeded either at an unrealistically stately pace, or they were mechanically recorded. So it would have been impossible, even if a record was kept contemporaneously as the interviews progressed, to keep a verbatim record other than  
H | by some form of mechanical recording.

- A Although it may be thought there was not complete agreement between Dr Hall and Dr Bentovim as to whether Dr Eastgate's actual notes were sufficient to satisfy the requirements of acceptable practice, neither of those two experts accepted that proper practice would require the taking of detailed notes during any of those sessions, let alone verbatim notes. Indeed, both of them were of the view that it was perfectly common practice for clinicians to take no notes at all during a therapeutic interview,
- B but only to record any notes subsequent to the interview. They explained the disinhibiting effect on an interview of a therapeutic nature that the taking of notes at the time can have.
- So neither of them accepted that it would be appropriate at any stage during any therapeutic interview to have a contemporaneous, let alone a verbatim, note taken.
- C I suggest, therefore, that the impossibility in reality of keeping a verbatim note in such an interview means that there is no basis on which the Committee could properly find that the absence of verbatim notes is to be castigated as a failure.
- D That is an easy way out for me in effect, because it means I can avoid – if that be a correct submission – the rather more difficult area of “Well, whether it needed to be verbatim or not” – and that is what is charged – “whether or not it needed to be verbatim, should it have been rather fuller? Was it adequate?” In case the Committee does feel able, despite my submissions, to go on to read the charge as not saying what it actually says, but as saying that “You failed to keep adequate notes” – and I emphasise, I submit it is not appropriate for the Committee to proceed on a basis other than that which the complainants have chosen to actually charge – but if the Committee were to go on to consider were there adequate notes, rather than verbatim, then I had better briefly address that issue as well.
- E The reasons why it has been said it is necessary to keep detailed notes are firstly so the precise circumstance of a first allegation are known, in the event that there are any court proceedings in the future; secondly, for the assistance of any other doctor who has to deal with the patient; and thirdly, for the protection of the clinician himself. I hope I have spotted all the reasons why it is said to be important to keep a note.
- F So addressing those in turn, the advantage of knowing the precise details of the making of the first allegation in the event of court proceedings is, of course, to make it easier to meet assertions that the disclosure was or might have been induced by leading questioning. So you have someone who has been charged with sexual assault up in front of the crown court, and counsel on behalf of the defendant says “Well, let's just analyse how these allegations first came out”, when they are looking to see whether they are true or not. “Here is a disturbed young girl, she'd say anything that anyone wanted if enough subtle pressure was put on her. We need to see exactly how this came out. Ooh – haven't we got a record of exactly how it came out? Well, there you are, then. You can't be sure about anything” – end of case; a possibly guilty person gets away with it. That is, putting it in summary form, what is said to be the importance of a detailed note.
- G
- H But anything other than a wholly verbatim record is still going to give rise to those sorts of issues, and still does – as anyone who practises in the crown court and does

- A those sorts of cases will confirm. Anything other than a verbatim record can and usually does leave scope for issues to be raised about that. If you have a note ---
- THE CHAIRMAN: Can I just raise one issue which is confusing me. You made a difference between a verbatim note and a wholly verbatim note.
- B MR TURNER: I should not. That is ---
- THE CHAIRMAN: And I would have thought that is of great significance to practising doctors in their everyday work. There are times when an account including some of the patient's own words, whenever it is written, is very useful.
- MR TURNER: Of course.
- C THE CHAIRMAN: That is what I would be suggesting to the Committee was meant by a verbatim note. It is not a wholly verbatim note, and they may prefer not to get into the question of verbatim at all and, as you say, to consider whether the notes were adequate.
- MR TURNER: Adequate ---
- D THE CHAIRMAN: That may be the way out. But you did refer both to verbatim and wholly verbatim.
- MR TURNER: Well, if I did ---
- THE CHAIRMAN: Wholly verbatim would seem to be to be a transcript.
- E MR TURNER: "Wholly verbatim", I submit, must be a transcript, indeed, and "partially verbatim" would, as you rightly say, sir, be a note, and one often sees such notes, where: "I asked the patient whether so-and-so, and she said", and then in inverted commas what she actually said, so one knows precisely what she said.
- F But, of course, that would not really help in this situation because what you need is the verbatim element of the question that induces the answer or leads to the answer as well. So without the whole thing being verbatim, word for word, you still run into these sorts of problems in any litigation in the future. Even if you have a partially verbatim note or a full, contemporaneous note or a much fuller note than we have here, you still have counsel for the Defence saying, "Oh, yes, you say she said, and you have put it in inverted commas, and you are sure of that. First of all, how can we be sure you got it down right in the first place, Doctor? There is no mechanical recording of it. How can the jury be satisfied you have even recorded her words correctly? Then where is the recording of your words? If there is such a recording, how do we know you got that down correctly? It must have been impossible to write all this down when you were there in a therapeutic discussion with this young lady."
- G So the only thing that is going to satisfy those concerns is, I suggest, a mechanical recording. Even then, one knows from experience, there are problems because if there is just a tape recording, people say, "Oh, well, you cannot see the subtle
- H nuances of" ---

A THE CHAIRMAN: I think you should continue.

B MR TURNER: So my suggestion in relation to all of this is, if the concern is that you make it more difficult in legal proceedings subsequently, then the answer is that nothing short of a full mechanical recording is going to alleviate those problems. So what the doctor has to do in this setting is bear in mind that if there is any possibility of court proceedings, there is going to be, firstly, a full memorandum interview conducted by a skilled interviewer who knows the rules of evidence that a doctor cannot be expected to know. Secondly, if there are criminal proceedings, the girl herself would have to give evidence and be tested, whether by way of a video link procedure, or whether live actually in court.

C That is what Dr Bentovim was getting at when he tried to explain to the Committee that, really, those are not actual factors that should cause one concern in relation to the fullness of the notes. Dr Bentovim dismissed as untenable that the notes of a session conducted for therapeutic sessions should be judged against anything other than a purpose for which they are required in therapeutic work. He said they were adequate for that purpose, certainly as perceived at the time, even though it would now be better in this context if they had been fuller.

D I suggest that if one looks carefully at Dr Hall's views about that overall, they are not wildly different from that. Of course, we all, when we are asked about it now, say, yes, of course now it would be better, but was it acceptable at the time?

E As to the second of the asserted needs for fuller notes, to assist others who may become involved in the management of the patient afterwards, really, Dr Eyre this morning has confirmed exactly what Dr Bentovim told you last week. In reality, it would be extremely unlikely that anyone covering for Dr Eastgate would be remotely concerned with the notes at all, let alone with the detail of the precise way in which the allegation had come out, what words had preceded it, what words followed it.

F If such a cover consultant be required to deal with any matter at all, he has the advantage of the members of the team who have been working with the doctor at the time. He has his own ability to ask questions of the patient, to have a session with the patient. He is not concerned with the legal niceties of what may or may not happen in the future.

THE LEGAL ASSESSOR: Mr Turner, you have identified three potential reasons there in paragraph 52 in your skeleton argument.

G MR TURNER: Yes.

H THE LEGAL ASSESSOR: I just wondered whether you would wish to address the possibility that there is a fourth one, or possibly a variant of number 2, and that is that detailed notes might be necessary for the assistance of the doctor himself in his treatment of that particular patient, because I think there was some evidence from Professor Zeitlin to the effect that keeping careful records in therapeutic sessions was regarded as being important or even more important by some people than keeping detailed notes of investigative interviews.

A I may or may not have understood it correctly, but it sounded rather as if the point was this, that the therapist would treat a person who had indeed and in fact been abused differently from the way he would treat a patient who had not in fact been abused and, therefore, at some time in the course of the therapy it might be important for the therapist to be able to go back to the detailed note of the very first, it has been called, disclosure and ascertain whether the circumstances of that disclosure were such as to suggest it was a genuine one or not a genuine one.

B  
C MR TURNER: Certainly it is absolutely right to say that there might well be different forms of therapy for someone who is making a true allegation of sexual abuse as opposed to someone who is making a false allegation. Someone making a false allegation may have other problems that need to be addressed that cause them to make such false allegations, but, of course, the clinician who is dealing with it will have his own knowledge.

D I suggest that all he needs are triggers. It is perhaps really a counsel of perfection to expect much detail of the form that the questioning took. The clinician, for his own purposes, will need a trigger to what has happened, but he will have his own knowledge of how things have come out and will have to make his own judgments in relation to the matter.

E These are professional judgments that can properly be left to professional men in the way they actually treat. Certainly if someone else needs the document, then I accept it is important that the document fulfils that person's needs in so far as it can, but the primary concern here that the doctor in the therapeutic context has, who is not an investigator, is a concern for his patients.

F It can be said it would be much better if every doctor from GPs upwards kept absolutely full notes of everything that a patient says when they come in and say, "I have a sore toe, Doctor" and "How did it happen" upwards, but that is usually with the benefit of hindsight. A doctor dealing with someone here as an inpatient will clearly have an ongoing knowledge of her situation.

G As far as the fact of watching his own back is concerned, if I can put it colloquially in that way, that, I suggest, is a matter for the doctor to concern himself with, and that cannot be a justification for a finding of unacceptable behaviour, you first protect yourself properly, let alone serious professional misconduct.

H The allegation relating to the notes, just looking at each of them very briefly that feature in head number 5, relating to the second session, of course overlooks the fact that the allegations did not commence until partway through that session; so it is a little bit unrealistic to expect a conversion from therapeutic to investigative at that stage, although Professor Zeitlin was suggesting it was easy.

H One only has to look at some of the literature on the topic, Dr Jones and the evidence he gave to the Cleveland report, to see that Dr Jones was very concerned that really riding two horses, the therapeutic work together with investigative work in parallel, was really impossible, according to the evidence that Dr Jones gave to the Cleveland report. It is impossible, I suggest, to expect Dr Eastgate to have been fulfilling both

A of those roles in the individual sessions that he had. At the end of paragraph 56 I have highlighted the reference to the evidence that Dr Jones gave to the Cleveland Inquiry in that regard.

B Then we have the file note for the session on 16 July which followed the strategy meeting. I am sorry. I have not dealt with 10 and 11 July because they feature individually in the head of charge. Those were still therapeutic sessions in which Dr Eastgate was, I suggest, doing exactly what it is said he should have been doing, namely, continuing to sound out and check the allegations for veracity, consistency; they were still being made; further checking whether anyone had been there with her, the grandmother, she said, so that he could then take his decision on the 12th about what to do now, that difficult decision for professional judgment.

C Then the file note of 16 July which followed the strategy meeting, and particularly when read together with the written document that is referred to in it, which was on the file as well, which is D2, was indeed, I submit, a very full record of what happened on 16 July.

D Then we have 19 July. Of course, there is no file note at all, certainly that we have now, of that. All that we have is the letter of 19 July which was addressed to the nurse who was in charge, the member of the team, who would be keeping an eye on things primarily during Dr Eastgate's absence.

E According to Dr Bentovim, that was adequate for its purpose, although not ideal. Dr Bentovim did not pretend to suggest that it was an ideal recording, but it was enough for a trigger. The pressures of "real world" are perhaps most relevant to that date because we know it was the date that Dr Eastgate was preparing or trying to deal with matters before going off on holiday. I say not an excuse, but an explanation for why a fuller note was not kept.

F What must be borne in mind when looking at that 19 July note was, although it seemed at one stage Dr Eastgate was saying that that was when an allegation of breast touching by the father was made, when he thought about that, he was not quite so sure he might not have been confusing that with a later session that he had with the girl when he got back from holiday.

G In any event, he also told the Committee - this may be important - that he did not actually want to put any more detail about that discussion he had had with the girl because he did not, I think his words were, want to "set up" his nursing team. He did not want them to be going in in the expectation of things being said that may be a complete red herring, may be nothing. He did not take that as a serious matter. It was not a child protection matter at the time. It was simply something an eye needed to be kept on, and when he returned he would consider what had happened.

H It should also be borne in mind, as I suggest, that the emphasis on making full notes in clinical work has become stronger in the years since 1996. But, looking on to a different point which comes at the end, if there was any falling below acceptable standards in relation to note-keeping, then, albeit that is not what is actually charged against him, it is the verbatim notes, then I still submit that, looked at in context, although it is a matter that I suspect Dr Eastgate would not be guilty of now, with the

A benefit of hindsight, it is not a matter that is so serious in the overall context of things that it could amount to serious professional misconduct. It might amount to serious professional misjudgement, but that is not quite the same thing.

B Head number 6, the last of them, I suggest, in fact, this is the easiest of the heads for the defence. Head of charge number 6 - I hope I can take this relatively shortly because I have put a lot of cross-reference material in that the Committee can look at if they choose at leisure - concerns the actions taken by Dr Eastgate on 12 July. It alleges, first of all, they were premature in two senses. It says did not make sufficient checks beforehand and, secondly, that should have involved the parents before. He did not take reasonable steps to verify the truth of the allegations with the result that his communication of his concerns to others was inappropriate, unprofessional.

C I say that just cannot begin to hold water when one looks at all the literature to which I have made my cross-references, where what is spoken of uses words such as "concerns", "suspicions", "real concern" and "belief". A whole spectrum of different words are used, but the word that is mainly used is "suspicion".

D Of course, what is important is that no one, be they a clinical practitioner, be they a police officer, social worker, whoever, should be discouraged from consulting with others about their concerns, in particular should not be discouraged from consulting a professional multi-disciplinary team who are then in an ideal position to take precipitative action, to give mature reflection, to decide what investigation, if any, should take place. If there should be an investigation, whether there should be an investigation, will be the first issue to be decided at a strategy meeting and, second, who should take those steps.

E It is essential that the doctor does not become an investigator. All that he needs to have is a real concern, a suspicion. He is really then, I suggest, under a duty to share that with others. Just think of the situation he would be in if it all turned out to be true, other children had been assaulted in the meantime and he had never mentioned it to anyone, despite these allegations having been made.

F The proof of the pudding really is in the eating here. Investigations were made. It did not lead anywhere. Everything was fine in a sense. Appropriate consultation was made; appropriate investigations were made. The fact that it did not lead anywhere does not mean to say that Dr Eastgate behaved inappropriately.

G The first question there is what level of suspicion must exist before a step is taken that may lead to the holding of a multi-disciplinary strategy meeting; a matter which Professor Zeitlin himself accepts there is very little literature on apart from a paper that he was a joint author of himself.

H To what extent must the clinician play the role of investigator? It is important to bear in mind, the whole purpose of the setting up of child protection teams after the Cleveland report, the whole rationale of multidisciplinary strategy meetings, as recommended by Cleveland, was to ensure that careful consideration was given to concerns that abuse may have taken place before any sort of pre-emptive action takes place.

A The very intention of the Cleveland report was to set up procedures that would encourage cooperation between professionals, avoid precipitative action. So, in those circumstances, I suggest that the doctor really should err on the side of caution if he has concerns or suspicions.

B It cannot be said here the doctor had no reason for concern. The girl had made an allegation with details. She maintained that allegation over a number of days. She had given an explanation as to how something may have happened, which, on the face of it, would seem unlikely. We saw again in the Cleveland report that one must not just disregard even matters that sound like fantasy. Right at the beginning of the report, chapter 12.6, the boy came out with a story that was regarded as being just too fantastic to be credible, but it turned out to be true.

C Should the doctor really, then, having those concerns, against that background, have done more? The proper filtering stage, I suggest, is a strategy meeting. The authors of the Cleveland report highlight the need for cooperation between various child protection agencies. They highlight the difficult and delicate line between taking action too soon and not taking action soon enough. But a strategy meeting, I emphasise, is not the taking of action. It is the point at which a decision is taken whether to take action.

D So, in that sense, the strategy meeting is an appropriate filtering stage. The Cleveland authors also emphasise the need to ensure that professionals do not stand back and ignore risks. I set out all these cross-references.

E What the Cleveland inquiry recommended to reconcile the problems of taking action too soon and not taking action soon enough was the setting up of multi-strategy teams, that was the answer as the Cleveland inquiry saw it to that dichotomy, that problem between too soon or too late. There should be a more multi-disciplinary consideration of that.

F The recommendation made in the Cleveland report as to inter-agency co-operation states that the practical issues of what level of suspicion should exist before the police are informed and relating to the involvement of parents needs to be recognised at a local level in careful discussion between the respective agencies. So in other words, set up your own guidance locally. The Wiltshire guidance does exactly that. But at paragraph 8 (c) of the recommendations in the Cleveland report itself and the sort of framework that local guidance should follow is set out. I invite attention to that because I suggest that the Wiltshire guidance follows exactly what Cleveland suggested. The word “suspicion” is used in the Cleveland guidance. I draw attention to page 251 in the Cleveland report which talks of the need to refer cases to a multi-disciplinary team when a member of one of the relevant agencies becomes  
G “suspicious of the possibility abuse having occurred ... or where there is uncertainty as to whether or not abuse has occurred”. Against that background, if there is a suspicion or uncertainty, does that really fit in with the assertion that you can be sure beyond reasonable doubt that Dr Eastgate should have done more in this case to verify before he went off and consulted another appropriate professional skilled in child abuse matters?

H

A I then invite reference to the national policy document that following Cleveland, the Working Together document, and there are a whole host of references set out in paragraph 64, and then the local guidance in paragraph 65. Again, the references are there that we have looked at during the course of the hearing which all speak of suspicion, the need to involve our agencies as soon as there is cause for concern. Finally, there is the reference to the DHSS guidance on which I have placed so much weight during the evidence in the case. Again, I am sure you are very familiar with that and I do not need to take you to it now.

B As to the stage at which the parents should have been involved. It is clear again from the Cleveland recommendations, if one looks at those cross-references I have made, that it must be a matter for local policy and the particular circumstances of particular cases.

C Mr Evans gave evidence about his recommendations that he said he made to Dr Eastgate and the reasons for it. Essentially, speaking to the parents may be seen as part of the evidence-gathering process in such a case as the present and it should then be left to the appropriate agency that has skills in evidence gathering, not to doctors. Doctors may have certain skills but their skills are not necessarily those of an investigator who is familiar with legal proceedings. It should be left to the appropriate agency following a decision at a strategy meeting.

D Dr Bentovim explained that the guidance as to the desirability of involvement of parents relates primarily to the process that is followed once a decision has been taken to pursue investigations, not to the taking of a decision whether to pursue investigations. All that is necessary there is the professional (or anyone else indeed) has a suspicion or a concern, whether they are uncertain or not about it.

E Dr Eastgate could not have been properly criticised for following the recommendations of Mr Evans if the concept of working together is to have any meaning at all.

If Dr Eastgate is open to criticism at all it is as Miss Glynn pointed out the fact that he did not follow the recommendations of Mr Evans, and he told the parents more than Mr Evans said was appropriate and before Mr Evans had said it was appropriate.

F What he could be open to criticism for is doing more to keep the parents informed than he had been advised to do.

G His diary notes indicate that he may have had it in mind to speak to the parents from the date of that first disclosure on the 9<sup>th</sup>. We do not know. He only speculates and says himself it would be dangerous to speculate as to why he had written that in and written it in on that date, but it maybe (can you exclude the possibility) that he had it in mind to speak to the parents from the date of that first disclosure? He knew the mother was coming on 12 July. It is perhaps not something one wants to speak about on the telephone. By that time, however, the thing had been pre-empted because his concerns had been such that when Mr Evans had seen him about another matter he had mentioned this matter at the end. Mr Evans was there. He did not have the chance then to tell the parents anything between his consultation with Mr Evans and the referral because Mr Evans said, "I am making the referral and that's that".

H

A | did Dr Eastgate do immediately that afternoon? He went back to the hospital and saw the mother and told her pretty fully what was happening.

It could be said there was too much involvement of the parents, although that is not what Dr Eastgate is criticised for, because the consultation with Mr Evans was an informal consultation of the sort recommended in the DHSS guidelines. Can it really be said that Dr Eastgate is open to criticism for discussing it informally with a fellow professional before informing the parents? I suggest that is certainly not something one could say, “Beyond reasonable doubt, yes, that was wholly inappropriate and unprofessional.” These are fine matters of professional judgment. There is a spectrum of possible reactions and causes that can be followed.

B

Our summary of how those allegations should be dealt with is set out in paragraph 69.

C | Generally, in relation to the inappropriate, unprofessional and failure allegations that are made, if anything they are errors of judgment. We suggest they are not errors at all, that each and every matter where there is criticism is in fact within the bounds of acceptable behaviour. But even if they are errors of judgment, errors of judgment do not amount necessarily to inappropriate or unprofessional behaviour or failures, let alone to serious professional misconduct. You have seen *Silver* and the relevant paragraphs of *Silver v. The GMC* already. It is a fact of life, we all make errors, even experts, and the present type of case gives rise to a mass of difficult and sensitive decisions providing plenty of scope for differences, plenty of scope for errors I suppose it could be said as well. We are all learning from our experiences throughout our careers, and who of us can say, “I have never made an error and I have always done it absolutely the right way when I look back on it. If somebody crawled over my notes or whatever they would not be able to criticise them”?

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E | On that topic it is useful I suggest not only to bear in mind what is said in *Silver* but also because it is important in the field we are concerned with to bear in mind what Lady Justice Butler Sloss, the author of the Cleveland report said in the *Re M (Minors)* case, and we have already looked at it. It is our document D4, page 830. You will recall there were criticisms being made in the individual case of Dr Jones, the author of one of the texts on the matter, and Lady Justice Butler Sloss in relation to those allegations that Dr Jones had been guilty of inappropriate questioning said:

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“Dr Jones is a distinguished child psychiatrist who is particularly experienced in interviewing children. That does not mean that he may not stray outside the principles of good practice which guide the experts in this difficult and delicate area of interviewing young children.”

G | Whether or not he had does not matter. What is important is that acknowledgement that even the most expert professional in this field could easily stray outside the appropriate boundaries.

H | Finally on this point, I also pray in aid what I have suggested is a combination of good practical common sense to be found in the combined words of Shakespeare and Lord Denning, and that is to be found in an extract from a law report, which is the last two pages annexed to the back of my submissions. It is a case brought by the famous late Mr Maxwell against the Department of Trade and Industry. What had happened was

A that there had been a Department of Trade and Industry inquiry at one stage into some of the activities of Mr Maxwell and they had found against him in some regard or other. Mr Maxwell then brought legal proceedings, judicial review proceedings to try to quash the decision of the Department of Trade inspector. Maxwell tried to quash it on a number of bases, one of which was that the inspector had been guilty of certain errors and oversights in the way that he had approached his task. What Lord Denning said about that can be found at page 536 of that report. Having set out the background  
B Lord Denning said this at B, which I have marked on the copies:

“I am not going further into all the details to which we have been subjected, for this reason: I think this line of attack is entirely misconceived. It must be remembered that the inspectors” (for inspectors read doctors) “are doing a public duty in the public interest. They must do what is fair to the best of their ability. They will, of course, put to a witness the points of substance which  
C occur to them – so as to give him the chance to explain or correct any relevant statement which is prejudicial to him. They may even recall him to do so. But they are not to be criticised because they may on occasion overlook something or other. Even the most skilled advocate, expert in cross-examination, forgets now and again to put this or that point to a witness. And we all excuse him, knowing how difficult it is to remember everything. The inspector is entitled to at least as much consideration as the advocate. To borrow from  
D Shakespeare, he is not to have ‘all his faults observed, set in a notebook, learn’d, and conn’d by rote’ to make a lawyer’s holiday. His task is burdensome and thankless enough as it is. It would be intolerable if he were liable to be pilloried afterwards for doing it. No one of standing would ever be found to undertake it. The public interest demands that, so long as he acts honestly and does what is fair to the best of his ability, his report is not to be impugned in courts of law.”

E I seek to draw analogies to that with the role of a doctor investigating disturbed children. It is a difficult task to perform and is he, as it were, to have all his faults observed and make a lawyer’s holiday?

Even if this Committee should conclude they are sure beyond reasonable doubt that the facts alleged in the heads of charge are made out, nevertheless I submit that proof  
F of any such facts cannot in the particular circumstances now fully known amount to or justify a finding of serious professional misconduct. They are not even at this stage capable of justifying that from the facts as this Committee might find them.

I am not going to set out in detail the points I have set out in bullet form in paragraphs 73 and 74 of my submissions. I invite the Committee to read those at leisure. They are in a sense a repetition of what I have already said but now all of the evidence is  
G available, and the whole context can be seen.

Sir, in those circumstances I invite the Committee to say that this case should go no further.

THE CHAIRMAN: Thank you Mr Turner.

H MISS GLYNN: Sir, may I just say one thing very shortly.

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THE CHAIRMAN: Yes.

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MISS GLYNN: Of course I have the right of reply to anything that has been said by counsel for the defence. It is merely this: in relation to Heads of Charge 3 and 4 your attention has been brought to the specific wording of the allegations and it has been suggested to you that you need to consider very carefully whether there is evidence that those words were said during the sessions. Of course I did not know this point was going to be taken when I addressed you. There are simply three passages, could I give you the references which may help you at this point, all references to Dr Eastgate's own evidence, the first is Day 4, page 31 E to the bottom of the page and just over. The second is Day 4, page 65, G to the bottom of the page, and Day 4, page 69 A to B.

C

Thank you.

THE CHAIRMAN: Thank you very much.

MR TURNER: Sir, may I just respond to that?

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THE CHAIRMAN: Yes.

MR TURNER: Yes, certainly those references can be made to what Dr Eastgate said in his evidence, but I ask the Committee to consider whether Dr Eastgate was actually saying, "Yes, I can confirm that these precise words were used" or was he simply saying, "This was the gist of what I said, I accept, yes words to this effect", but how on earth would he or anyone be able to remember after seven years the precise formulation of words and the precise context of them.

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THE CHAIRMAN: It seemed to me that these were quotations from his notes rather than anything that he necessarily said.

MR TURNER: Yes, but the problem is that his notes do not purport to be verbatim, and we come back to that again. His notes only purport to be a summarisation.

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THE CHAIRMAN: Yes, but I take the heads of charge to be quoting from his notes.

MR TURNER: Yes, that is where the heads of charge come from but it treats the notes as if they were verbatim and then, of course, criticise him on the other hand for them not being verbatim.

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THE CHAIRMAN: The Committee will now adjourn until 2.10, when I shall call on the legal assessor to advise the Committee.

It has been suggested to me as the gallery is now very full that I should remind the press that we have asked that anonymity of the particular people in the case should be respected, and we would be very grateful if that was so. There has not been any problem at all I think, and I do not anticipate there will be.

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(Luncheon adjournment)

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