

The President
of the Family Division
Working Group on Medical
Experts in the Family Courts
Draft report
(for consultation)

November 2019

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Introduction

In Autumn 2018, The President of the Family Division, Sir Andrew McFarlane established a working group to identify the scale of the problem of medical expert witness shortages in the family courts, to look at the causes and to identify possible solutions. Mr Justice Williams was appointed to Chair the group with representation from the legal profession and Royal Medical Colleges. The list of the members of the working group is:

Mr Justice Williams	Chair
Rebecca Leharne	Secretary
Dr Alison Steele	RCPCH
Dr Adam Oates	RCR
HHJ Kharin Cox	Judiciary
Melanie Carew	CAFCASS
Dr Mark Corcoran	BMA
Dr Jan Wise	BMA
Eleanor Druker	Legal Aid Agency
Dr Alison Firth	RCPCH
Sharon Segal	ALC
Alistair Henderson	Royal Medical Colleges
Dylan Jones	Law Society
Frances Judd QC (now Mrs Justice Judd)	FLBA (now Judiciary)
Samantha Little	Resolution
Naomi Madderson	FLBA
Caroline Makin	Resolution
HHJ Gillian Matthews	Judiciary
Rachael McKeown	RCPCH
Jo Revill	RCPCH
Rachel Rogers	Resolution
Nadia Salam	Resolution
HHJ Malcolm Sharpe	Judiciary
Rebecca Stevens	Law Society

The impetus for the establishment of the working group was the feedback the President of the Family Division had received arising from his nationwide progress around the family courts following his appointment in July 2018. The group sits within the broader structures and work promoting child safety and protection.

The working group decided to adopt the following process.

- a) Survey the medical and legal professions to establish an evidential foundation in respect of the extent of the problem, perceptions of causes and potential solutions. To that end medical and legal sub-groups were formed.
- b) A symposium to discuss the survey results
- c) A draft report to be sent out for consultation in Winter 2019
- d) Final Report to be presented to the President in Spring 2020

We believe that health professionals play an important role in providing expert opinions to the Family Courts to assist the Court in making the essential decisions for both the welfare of the child but also to protect the rights of the carers. Both health and legal professions have long shared concerns regarding the relative scarcity of medical expert witnesses willing to participate in family cases involving children.

Providing reports to the family courts is hugely time consuming and requires meticulous scrutiny of medical records and radiological imaging. With the complexities and demands of practicing in the modern NHS, it is perhaps not surprising that few individuals are willing to take on the challenges of being a medical expert. However, the role of the medical expert in the Family Court can be greatly rewarding and clearly the protection of the vulnerable child is the responsibility of all.

Proposed solutions to the challenges faced by expert witnesses are listed at the end of the report. Recommendations within the remit of health have by and large been the product of the medical subgroup. Recommendations that are outside the remit of health have by and large been the product of the legal subgroup. However there has of course been substantial overlap and cross-fertilisation and the ultimate recommendations are those of the full working group rather than the subgroups.

Although the working group was satisfied that the survey had reached an appropriate cross-section of experts and legal professionals working within the family justice system, the working group recognises that a number of the recommendations impact upon and would require implementation by various stakeholder bodies at national and regional level, and so before finalising our recommendations the working group recognises that it is essential that the draft recommendations are put out for consultation in particular to those agencies who would be most affected and whose input into the crafting of the solutions would be so essential.

We hope all the recommendations will be capable following consultation of being actioned to ensure expert witness work is attractive to health professionals and that experts are appropriately supported to provide this work. Some are capable of relatively rapid implementation; others may be long-term goals which will require the existence of a body which will be capable of taking these recommendations forward whilst monitoring and supporting the implementation of short and medium-term measures.

I am particularly heartened by the progress made already in discussions with the Legal Aid Agency (LAA) to simplify the process by which prior authority for experts is secured and how the experts are paid (see Section (v) paragraph 34)

Ultimately, a strengthened expert witness workforce will together with the legal and other professions deliver the best outcomes for children, young people and families.

I would like to express my thanks in particular to the members of the working group but also to all those who responded to the survey, attended the symposium, or who have otherwise contributed to this draft report. It has been a considerable undertaking and as ever has relied upon the generosity of time from those who have so little time to spare in their busy working and family lives.

Mr Justice Williams

15 November 2019

Executive Summary

1. The survey of the medical and legal professions was responded to by 709 individuals (412 + 297) achieving good geographical and specialisation coverage. The working group was satisfied that the survey results provided a reliable evidence base from which to gauge the extent of the problem, the actual and perceived causes and to identify solutions that were likely to have real effect. The survey results were consistent with the concerns expressed to the President of the Family Division which led to the formation of the working group and with the experience of the members of the working group. Although there were some observed gaps in the response rate of some branches of the medical profession the working group concluded that this was almost certainly a product of variations in the means by which the survey was notified to the professions rather than a lack of interest. The working group was also satisfied that those gaps did not affect the validity of the results.

2. The results of the legal survey confirmed that difficulties in securing expert witnesses were experienced across the country and in a wide range of specialisms. The impact of the shortages was principally in creating delay although there were also concerns about the quality of some expert evidence which appeared likely to be linked to the shortages. The detrimental impact of delay is enshrined in statute and in particular in relation to children under the age of three, where delay may have a direct detrimental impact upon the success of future placement, the working group were satisfied that the shortage of experts was likely in some cases to be harmful to children. The main shortages identified were
 - a.* Child and family psychiatrists and psychologists
 - b.* Paediatricians
 - c.* Radiologist and neuroradiologists
 - d.* Neurosurgeons
 - e.* Ophthalmologist
 - f.* Haematologists
 - g.* Neonatologists
 - h.* Geneticists

3. The results of the medical survey supported the conclusion that the pool of experts, in particular in some areas of specialism, was diminishing and a combination of factors was causing those who had previously reported to cease reporting and were acting as a disincentive to senior registrars or consultants considering taking on expert work in the future.

4. The main factors which were identified as barriers or disincentives were:
 - a. Remuneration linked
 - b. Court processes
 - c. Lack of support and training
 - d. Perceived criticism by lawyers, Judiciary and press

5. Some interesting variations appeared as between the lawyer perspective and the medical perspective. The most commonly expressed barrier amongst both groups is the Legal Aid Agency prescribed rate¹ but interestingly the lawyers identified this as a more significant barrier than the experts did which suggests the lawyers lacked a full understanding of the extent of the barriers. Other elements of concern about finances included delays in payment, the payment system (multiple invoices) and the tax/pension implications. 58% of healthcare professionals expressed concern about criticism in the press, by the judge or in cross examination. 38% of healthcare professionals identified inflexibility in court timetabling (including scheduling witnesses) as an issue and 37% the volume of material. Significantly 35% of healthcare professionals identified lack of support from NHS Trusts. The most significant disparities in terms of perspectives were in relation to legal aid rates and other aspects of finances, lack of support from NHS Trusts and the volume of material.

6. The wide range of barriers identified means that solutions will need to cover a wider range of areas than might initially have been thought and will require engagement at senior level with Department of Health and MoJ as well as NHS. The range and nature of the disincentives might seem to indicate a gloomy outlook in terms of effecting real change but the working group considers that this is not so. Firstly, there are some court process related factors which ought to be capable of effective resolution even in the short-term. Other potential solutions which are more structural and long-term in nature are also capable of resolution by action which is largely within the gift of the medical and legal professions. Other matters lie outside the power of those involved in the working group being in the hands of commissioning agencies (contract linked issues) or the Treasury (pension linked tax consequences) and will require more concerted action. The BMA amongst other are actively engaging the Government on this matter. However the working group are optimistic that even some of these changes are within reach given the compelling evidence and the enthusiasm of the agents of change.

¹ This is prescribed by Statutory Instrument and would require ministerial agreement and a negative SI to change.

7. Reassuringly there was considerable interest expressed by the medical profession in undertaking expert work and those conducting the work identified many positives both in terms of their clinical practice but also public service from doing so. There was also considerable support from the survey respondees to being involved in any initiatives which arose from the working group.

8. The working group has identified 22 recommendations to reduce the shortages by removing disincentives and creating incentives. The principal recommendations include;
 - a. Action by the Royal Colleges to create online resources to support expert witness work and to increase awareness of existing training in the field
 - b. The Royal Colleges to engage with commissioners and or trusts to promote a more supportive environment to medical professionals who wish to undertake expert witness work
 - c. The Royal Colleges and the working group to engage with NHS England and Clinical Commissioning Groups to seek changes to contracting arrangements to enable healthcare professionals to undertake expert witness work within the parameters of their employment contracts
 - d. Amending the Legal Aid Agency's guidance in respect of the granting of prior authority and payment to experts to simplify the process to enable an expert to render one invoice
 - e. Seeking changes to the rates of remuneration for certain experts and the prescribed number of hours in respect of some categories of assessments to more properly reflect the amount of work involved
 - f. Ensuring legal professionals including Judiciary adhere to the provisions of FPR Part 25 in relation to expert instructions
 - g. Ensuring that the instruction to experts was more efficiently undertaken to ensure only the necessary paperwork was sent to the expert to consider and a unified point of contact to ensure more effective and efficient communication
 - h. Ensuring that experts were only required to give evidence where the court was satisfied an issue existed in relation to their report, to guarantee if their participation was required that it was fixed and not susceptible to last-minute change and to enable experts to attend by video link where appropriate
 - i. Ensuring that experts are treated appropriately during court hearings, within judgments and thereafter to support constructive engagement and feedback
 - j. Creating a subcommittee of the Family Justice Council (FJC) to support and maintain the implementation of the recommendations

- k. Creating regional committees based on family division circuits to promote interdisciplinary cooperation, training and feedback.
 - l. To create greater training opportunities for medical professionals including mini pupillages with judges, cross disciplinary training courses with healthcare and legal professionals, and mentoring, peer review and feedback opportunities
 - m. To promote greater awareness within legal professionals including by means of training, of best practice in relation to expert witnesses
9. The working group invites consultation principally in relation to its recommendations although welcomes contributions on any other matter addressed in this draft report. We very much hope that the consultation will enable us to further refine the recommendations so as to craft practical effective solutions which will have traction in the environment which exists for both medical and family justice professionals. To that end we welcome feedback in particular in relation to the consultation questions found at Appendix 1.

Medical Survey: Analysis of Responses

This report outlines the results of a recent survey of medical and allied health professionals, which sought to further understand and quantify the perceived problem. Although the original aim was to explore barriers medical expert witnesses faced, a major finding from the survey was that a range of health professionals provide expert witness work and face similar challenges in doing so – throughout the rest of this section of the report, we will refer to health professionals to encompass both medical and allied health colleagues.

Report authors:

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Survey methodology

1. The aim of the survey was to investigate health professional’s experiences of providing expert witness work, the perceived barriers they face and any changes that would encourage them to take on expert witness work in the future. There were 16 questions in total (listed in Appendix A), which were devised by the working group and were aligned to questions asked within a separate survey provided to the legal profession.
2. The intended target audience for the survey was medical professionals practicing in England and Wales (in accordance with the area the Family Division of the High Court operates²). The primary scope was to consider shortages within family cases involving children and so the survey was targeted to health professionals working within the field of paediatrics and child health.
3. The survey was hosted on Survey Monkey for one month (April to May 2019).
4. There were 412 total respondents to the survey, although there were different response rates to individual questions. It has not been possible to quantify an accurate response rate to the survey, as it is not known by the working group how widely it was distributed. It was shared with the membership of: Royal College of Paediatrics and Child Health (RCPCH) via eBulletins and social media (Twitter), the Royal College of Radiologist (RCR) monthly newsletter, the British Society of Paediatric Radiology (BSPR), the Academy of Medical Royal Colleges (AoMRC), the British Medical Association and the Consortium of Expert Witnesses.

² <https://www.gov.uk/courts-tribunals/family-division-of-the-high-court>

- The survey results were analysed by two senior medical consultants (a paediatrician, Dr Alison Steele and a radiologist, Dr Adam Oates) and a member of the RCPCH Policy team (Rachael McKeown).

Demographics of survey respondents

- The majority of survey respondents (75.7%, n=309) were medically-qualified professionals, although a considerable number of allied health professionals (22.1%, n=90) also completed the survey, indicating that this issue is not solely in the sphere of medical professionals. Of the medical profession the biggest groups represented were paediatrics, psychiatrists, radiologists and general practitioners (see Table 1). The largest allied health group represented was psychologists.
- The low response rate recorded from surgeons (n=2) is surprising considering the important role neurosurgery and orthopaedic surgery play in cases of childhood head injury and fractures, respectively.

Table 1: Respondent’s Medical Royal College or Professional Association (qualitative responses have been coded and incorporated into this analysis)

	Number	Percentage (%)
Medical professionals	309	75.7
Royal College of Paediatrics and Child Health (RCPCH)	132	32.4
Royal College of Psychiatrists (RCPsych)	82	20.1
Royal College of Radiologists (RCR)	46	11.3
Royal College of General Practitioners (RCGP)	29	7.1
Faculty of Forensic and Legal Medicine (FFLM)	6	1.5
Royal College of Surgeons (RCS)	2	0.5
Royal College of Pathologists (RCPath)	2	0.5
Royal College of Physicians (RCP)	2	0.5
Royal College of Anaesthetists (RCA)	2	0.5
Royal College of Ophthalmologists (RCO)	2	0.5
Royal College of Paediatrics and Child Health (RCPCH) and Faculty of Forensic and Legal Medicine (FFLM)	2	0.5

Royal College of Surgeons (RCS) and Faculty of Radiologists	1	0.2
British Medical Association (BMA)	1	0.2
Allied health professionals	90	22.1
British Psychological Society (BPS)	51	12.5
Health and Care Professions Council (HCPC)	14	3.4
Health and Care Professions Council (HCPC) and British Psychological Society (BPS)	13	3.2
Association of Family Therapy	3	0.7
UK Council for Psychotherapy (UKCP)	2	0.5
British Psychological Society (BPS) and UK Council for Psychotherapy (UKCP)	1	0.2
Association of Clinical Psychologists (ACP)	1	0.2
British Psychological Society (BPS) and Association of Clinical Psychologists (ACP)	1	0.2
Royal College of Midwives (RCM)	1	0.2
Faculty of Public Health	1	0.2
Association of Child Psychotherapists	1	0.2
Chartered Forensic Psychology	1	0.2
<i>None (or not clearly specified)</i>	9	2.2

8. Just over half (50.6%, n=204) of survey respondents identified themselves as working within child health only and a further 1.2% (n=5) covered both adult and child health services. However, it should be noted that a number of respondents did not specify whether their practice covered child or adult health (see Table 2).

Table 2: Respondent's specialty area (medical students / trainees / junior doctors have been removed from this analysis)

	Number	Percentage (%)
Child	204	50.6
Consultant paediatrician	115	28.3
Child / child and family psychologist (inc. neuropsychologist & educational psychologist)	56	13.8
Child & adolescent psychiatrist (inc. family & perinatal)	26	6.4
Specialist in community paediatrics (inc. SAS)	4	1.0
Consultant neonatologist	2	0.5
Paediatric emergency medicine	1	0.25
Adult	81	20.1
Adult psychiatrist	51	12.6
Adult psychologist	30	7.4
Adult and child	5	1.2
Psychologist	5	1.2
Specialised consultant	59	14.6
Consultant radiologist (inc. neuroradiologist)	44	10.8
Consultant neurologist	3	0.7
Consultant anaesthetist	2	0.5
Consultant surgeon (inc. specialty doctors in surgery)	2	0.5
Consultant ophthalmologist	2	0.5
Consultant pathologist	1	0.25
Consultant haematologist	1	0.25
Consultant toxicologist	1	0.25
Consultant gastroenterologist	1	0.25
Consultant nephrologist	1	0.25
Consultant in genitourinary medicine	1	0.25

Primary care	28	6.9
GP / primary care	26	6.4
Academic GP	2	0.5
Forensic	12	3.0
Forensic Medical Practitioner	9	2.2
Forensic psychiatrist	2	0.5
Sexual offences examiner	1	0.25
Allied health professionals	8	2.0
Psychotherapist	3	0.7
Family therapist	2	0.5
Psychotherapist and social worker	1	0.25
Maternity safeguarding lead	1	0.25
Play therapist and social worker	1	0.25

9. The majority of survey respondents (89.9%) were based in England although there was a relatively even distribution recorded from the UK devolved nations. Comparison of the England-based respondents with the 2011 census data³, indicates that there was comparatively even representation from each region (see Table 3); although with relative over-representation from London (24.3% survey respondents compared to 15.4% in population census) and under-representation from the East of England (7.7% survey respondents compared to 11.0% in census).

³ <https://www.ons.gov.uk/census/2011census/2011censusdata>

Figure 1: Geographical spread of respondents

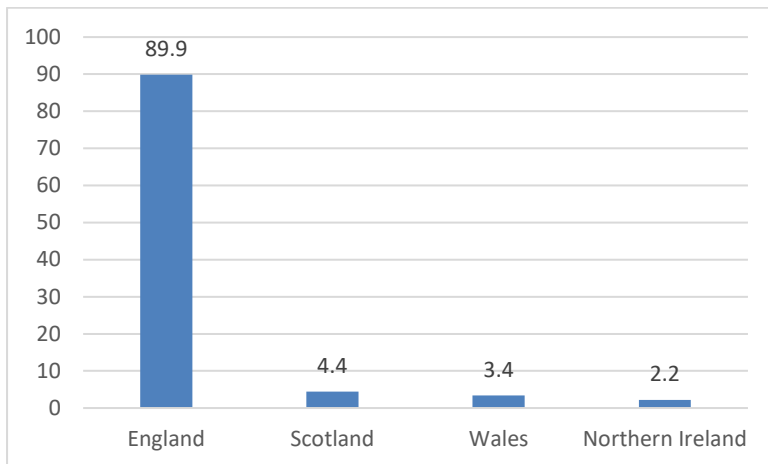


Table 3: Regional spread (England) of respondents

England	(n) 366	Survey %	Official %
London	89	24.3%	15.4%
Midlands	66	18.0%	19.2%
North East and Yorkshire	54	14.8%	14.9%
North West	48	13.1%	13.3%
South East	41	11.2%	16.3%
South West	40	10.9%	10.0%
East	28	7.7%	11.0%

10. Analysis of these demographic responses indicates that the targeting of the survey was largely successful in eliciting responses from health professionals working in child health from England and Wales. Furthermore, we feel that the geographic distribution of respondents is likely to provide a reliable base for the subsequent analysis.

Barriers facing professionals completing expert witness work

Previous experience of expert witness work

11. The majority of respondents (58.4%) stated they had not provided expert witness evidence within the previous 12 months. However, of these respondents 54.3% (n=171) had, at some point, previously provided this work. A further 45.7% had not previously

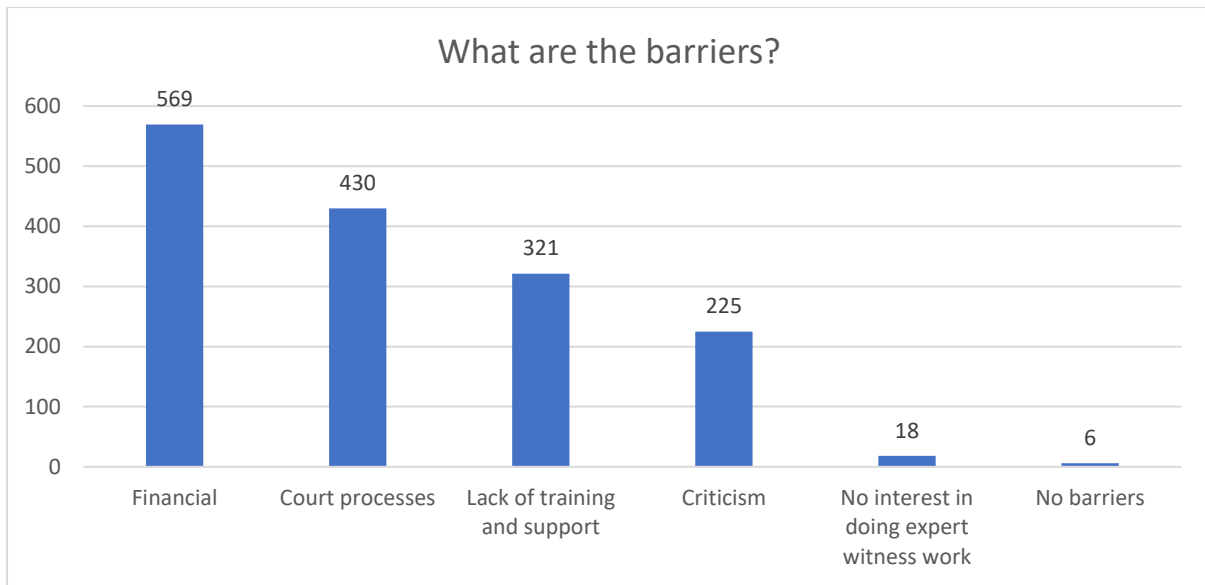
provided expert witness work. Arguably, the lack of recent engagement implies that health professionals face barriers preventing them conducting and returning to this work.

12. Encouragingly, respondents demonstrated good knowledge of the role of expert witnesses, with 95.2% understanding the difference between the duty to the court as an expert witness and that of a treating clinician. Furthermore, 69.4% had at some point previously provided a written report in court as an expert. These results may be indicative of the nature of survey respondents, who have an interest in this line of work and a survey of general medical membership may elicit different responses. However, anecdotally it is felt that many doctors do not understand the Family Court processes or the difference between professional and expert witnesses and this result is likely to be due to the interest of professionals that responded to this survey
13. However, 29.9% of respondents reported that they have never provided a written report in court as a treating clinician. We feel that it is essential for professionals to provide a report as a treating clinician (and gain feedback) before they engage in expert witness work, which indicates that there was a large number of respondents who have very limited prior experience with this work.

Overview of barriers faced

14. Respondents were asked to select the top five reasons (from a pre-determined list) preventing them from providing expert witness work. For ease of analysis, we have grouped the most frequently reported barriers into closely aligned themes (see Figure 2). A full breakdown of all options from the pre-determined list and number of survey respondents can be found in Appendix 2. The main barriers indicated as faced by health professionals are: financial (n=569), court processes (n=430), lack of training and support (n=321), and perceived criticism (n=225). Each of these areas will be discussed in turn below.
15. It is important that these reported barriers are considered alongside results from the accompanying legal survey, which asked lawyers to indicate what they perceive the barriers for expert witnesses to be. Analysis indicates that there are discrepancies between what is perceived by legal professionals and what is experienced by health professionals.

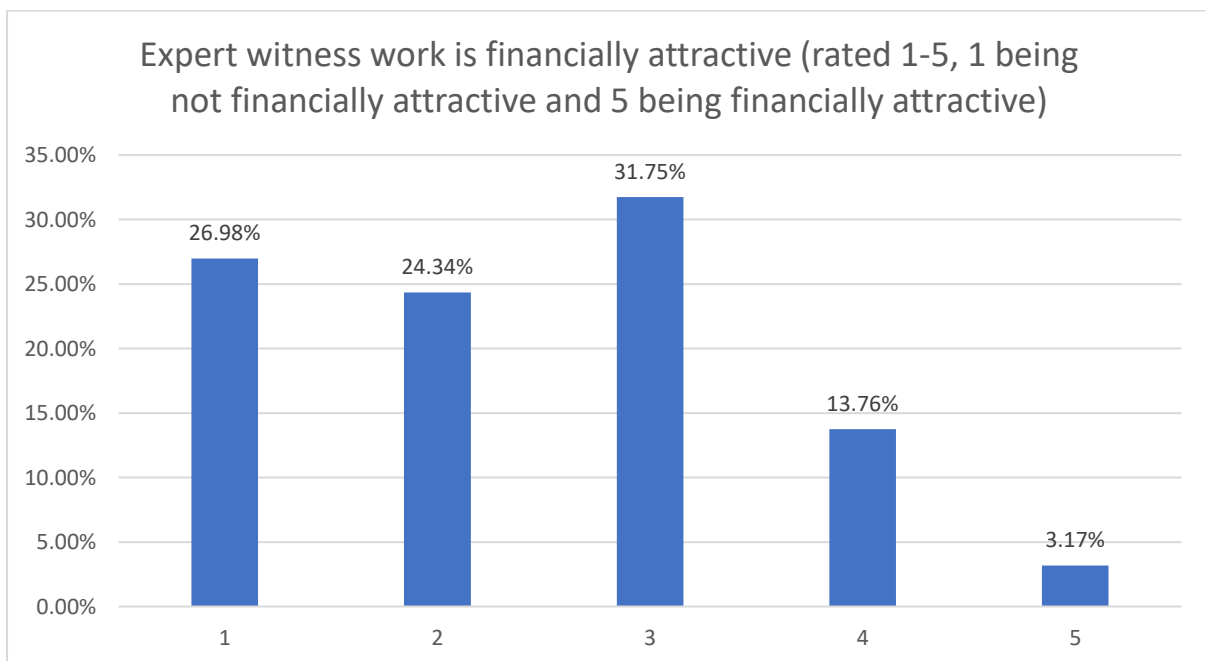
Figure 2: Response to ‘What are the barriers for medical professionals?’ (combined quantitative and qualitative responses, organised into themes)



Financial

16. Respondents were asked to rank how “financially attractive” they found expert witness work on a scale from one to five (1=not at all attractive, 5=very attractive) (see Figure 3). In total, 83.05% of respondents did not report that expert witness work is financially attractive, with only 12 respondents who found the work to be very financially attractive.

Figure 3: Response to ‘Expert witness work is financially attractive’



17. There were a range of different financial barriers faced by respondents, ranging from: inadequate rates of remuneration at current legal aid rates, an antiquated payment and invoicing system, slow receipt of payment and issues with pensions faced by many senior public sector workers including the Judiciary.
18. Qualitative responses expand on these barriers faced by medical and health professionals:
- “...in addition rates of remuneration were significantly reduced so in the end I didn't think the effort, the stress involved in "putting one's head above the parapet" was worth it...So I gave it up”*
- “Having to invoice 4 or 5 bodies for a single underpaid report is off putting, one body should be responsible for payment”*
- “Pay on receipt of invoice”*
- “Less antiquated system of payment, payment on delivery of the report I would have thought was basic for any viable business plan.”*
- “Speed up payment”*

Court processes

19. Many respondents expressed concerns as to how to dovetail a busy NHS practice with the perceived inflexibilities of the court system. There were indications that expectations for expert witness work varied between judicial and geographical locations for example in terms of acceptable timeframes for filing reports and the whether attendance at court was required in person or via video link. Both the examples cited have a very significant impact on whether an expert is likely to be able to take on a case and combine with their often inflexible and complex NHS practice. It was repeatedly noted that lack of appropriate organisation i.e. late provision of bundles and last minute cancellation of court attendance has implications on the time that health professionals have to dedicate to expert witness work.
20. The administration and organisation of Family Court bundles was a major concern for respondents. Bundles often contain vast quantities of information, frequently not well indexed. Health professionals noted an obligation to thoroughly read all information shared to avoid the potential of overlooking a key feature but, in reality, reviewing extensive contact reports (for example) are unlikely to be of relevance.
21. Respondents indicated that they wanted to provide expert witness work in order to improve outcomes for children and young people, however, were often left frustrated and disappointed when they were not made aware of the outcome of cases after their involvement.

22. These barriers noted led some respondents to suggest that lawyers had a lack of appreciation or understanding for the lack of time (not unwillingness) to provide expert witness work.

23. Qualitative responses expand on these barriers faced by medical and health professionals:

“chaotic approach of some instructing solicitors and the absence of a standardised approach by solicitors which results in not receiving the relevant documents, getting dozens of emails with individual documents...”

“Have the bundles reduced to what is relevant to the expert.”

“The work is emotive and distressing at times. You don’t always get feedback regarding the outcome of the case. It’s sometimes difficult in terms of planning the number of cases you have...”

Training and support for expert witnesses

Training

24. The majority of respondents (66.1%) have previously undertaken expert witness training. However, there was a large appetite among respondents for more training (see Figure 4). 58.6% of all respondents were interested in attending a training session and this figure rose to 67.2% for respondents who have never previously provided expert witness work wanting to attend training. While this presents an interest in engaging with expert witness work, there remains a considerable number of respondents (41.4%) who are not interested in receiving training; perhaps indicating that other barriers are insurmountable.

Figure 4: Response to ‘Would you be interested in receiving training to support expert witness work?’

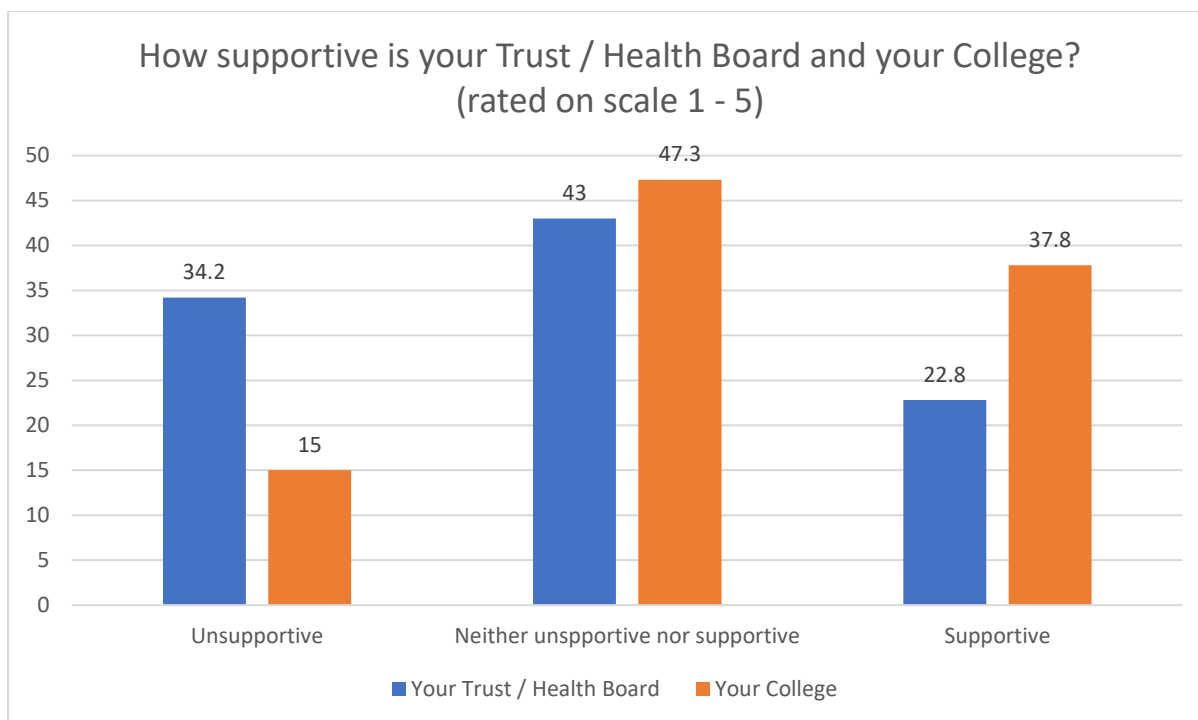


25. Respondents were asked to outline what they would like from expert witness work within free text comment boxes. Responses fell into two broad categories: what the training should cover and how the training should be delivered.
26. There was considerable demand for training on how to be an expert witness: how to prepare reports (n=54), how to give evidence in courts (n=53), what to expect courses (n=11). Alongside this, there was also appetite for refresher and update courses, which would cover developments in the law and medical diagnoses. These different responses indicate two different training needs, the former for less experienced professionals seeking to become expert witnesses and the latter for existing expert witnesses wanting to upskill and maintain their knowledge.
27. With relation to the delivery of training, a range of options was suggested by respondents. These included peer review, discussion sessions and mentoring schemes.

Support

28. The majority of respondents stated that they did not feel supported by their Trust/Health Board (77.2%) or by their Medical Royal College/Professional Association (62.3%) to complete expert witness work (see Figure 5). These findings indicate that NHS employing organisations and Clinical Commissioning Groups (CCGs)/service planners should be engaged in order to alleviate some of the barriers preventing professionals from providing expert witness work. Furthermore, additional analysis is required to ascertain what support respondents would like from their Medical Royal College/Professional Association.

Figure 5: Response to ‘How supportive is your Trust / Health Board and your College?’ (respondents were asked to rank the level of support on a scale from 1-5, 1 being no support and 5 being fully supported. Responses 1-2 have been grouped as ‘unsupportive’ and 4-5 have been grouped as ‘supportive’)



29. Qualitative responses expand on these barriers faced by medical and health professionals:

“Better support and awareness about the need from Trusts, and the College”

“That trusts would recognise the value of the work and actively support it with training as it is challenging work”

“Work between NHS Trusts and Family Court System towards an understanding that the needs of children and families are best met by supporting expert work”

Criticism

30. A number of respondents expressed a reluctance to engage with expert witness work due to anxieties surrounding unfair criticism, both within the Judiciary and the media. It is worth noting however that fear of critique was heightened in those who had not previously completed expert witness work.

31. Constructive criticism is an essential part of modern healthcare practice. It is essential for health professionals to learn from mistakes in order to improve the care they provide for future patients. However, survey responses highlighted situations of perceived unjust criticism (by a judge and the subsequently the media) possibly secondary to a misunderstanding due to the complexity of a particular case. While clearly maintaining strict independence is essential, closer networks between the medical, psychological and legal professions, along with the Judiciary may alleviate some of these concerns.

32. These concerns were borne out in qualitative responses from medical and health professionals:

“I feel very nervous about taking on this work even though I regularly produce reports for court on patients...I am anxious about potential media coverage.”

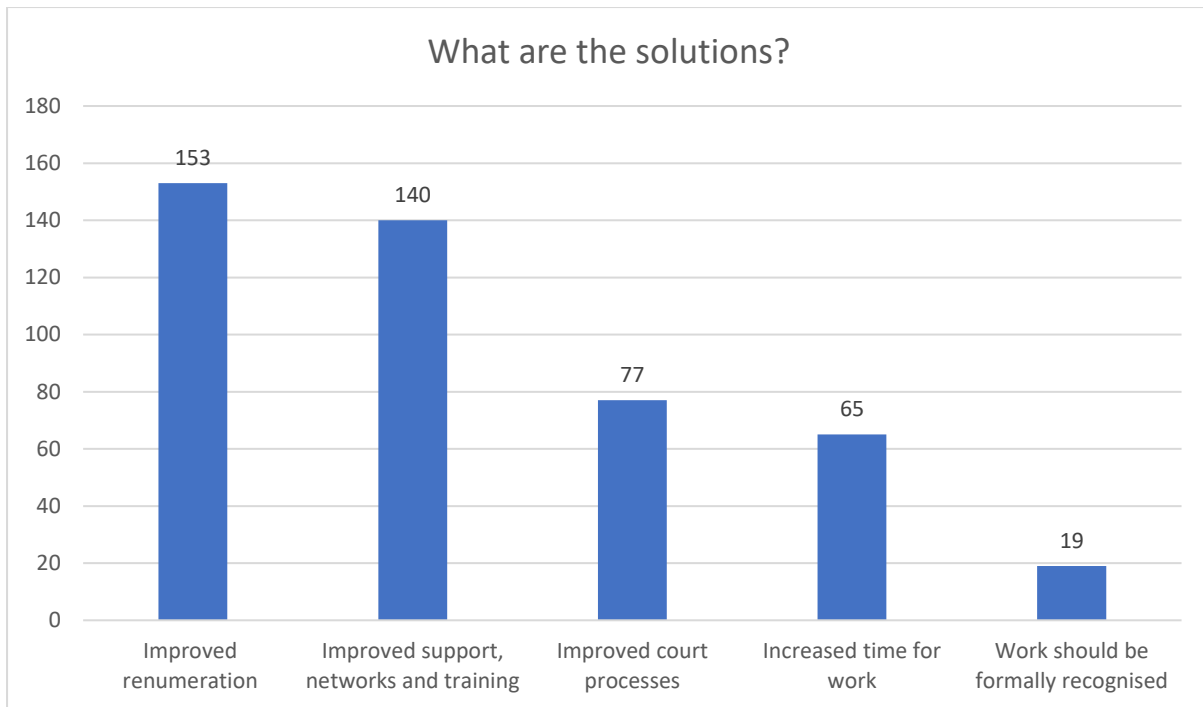
“Better protection of expert witnesses from unjustified and unfair criticism by families, media and Judiciary”

“Currently undervalued work where clinicians put their expertise on the line and are likely to be criticised by the media”

Proposed solutions

33. Respondents were asked to provide suggestions for solutions to overcome the barriers they face when acting as (or preventing them from acting as) expert witnesses; they recorded these suggestions in free text responses, which have been thematically coded for analysis here. Respondents may have offered multiple solutions.
34. The proposed solutions offered by the respondents largely mirror the findings for the barriers they experience (see Figure 6). The top solutions health professionals would like to see are: improved remuneration (n=153), improved support, networks and training (n=140), improved court processes (n=77), and increased time to partake in expert witness work (n=65).

Figure 6: Response to ‘What are the solutions?’ (Qualitative responses have been thematically coded)



35. Qualitative responses expand on these barriers faced by medical and health professionals:

“Appropriate remuneration, paid on time when work complete. Better case administration by legal teams. More consideration to other work schedules by Court. Seek advice from the Consortium of Expert Witnesses to the Family Courts.”

“The fee could be paid to instructing solicitor who could pay it all in one go; payment could be released to instructing solicitor at point of approval”

“More realistic timescales. I have been asked to prepare complex reports within a month - I cannot do justice to the report.”

“Financial remuneration should reflect the expertise, actual time taken to write reports and skill required in this work.”

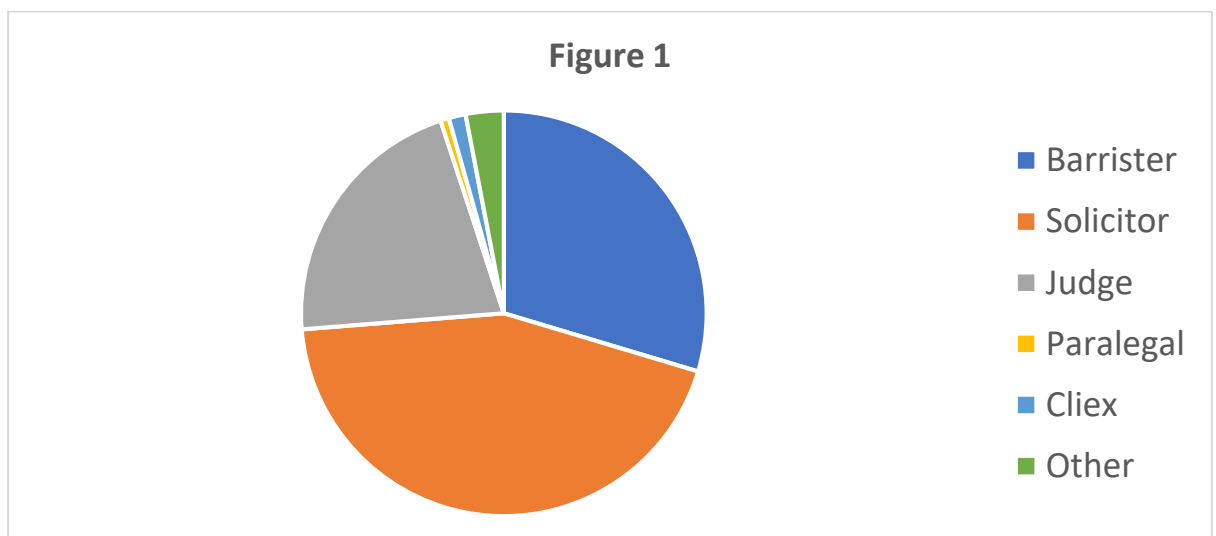
“Trusts benefit by increasing quality standards in the department and enhancing reputation and paediatricians are given time to spend on intellectually challenging, interesting and important work... Courts then also get real experts acknowledged by their peers, actually doing the clinical work on a day to day basis”

Legal Survey

1. The working group devised a set of 12 questions for legal practitioners. We sought to investigate and gather information as to the anecdotal, but widespread, perception of a shortage in medical expert witnesses in both public and private law cases throughout the country.
2. We aimed our survey at family law practitioners working within the family justice system and the Judiciary. It has not been possible to calculate a response rate to the survey. Family law practitioners were made aware of the survey via their professional body whether Resolution, the Family Law Bar Association or the Association of Lawyers for Children. Those professional bodies have vast membership, not all practice within the public and private law children arena; some professionals are a member of one or more of those organisations. Some professionals were notified of the survey via their individual firms, or chambers and/or social media.

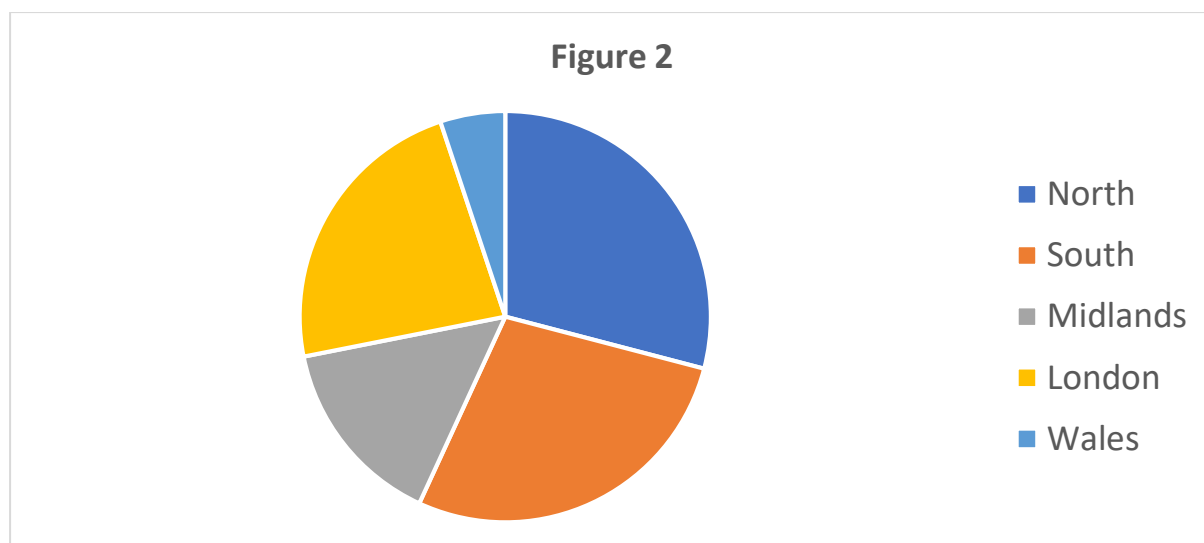
The Statistical Material

3. The legal survey had 297 responses: Barrister: 88 (30%), Solicitor: 131 (44%), Judge: 63 (21%) and Others: 15 (5%) [Figure 1]



4. We considered the number of responses, and were of the view that the spread across the professions, and as shall see, across the country, was such that the results were likely to provide a reliable base from which to draw conclusions.
5. Respondees were asked in what area of the country they mainly practised in. The results suggested that some respondents worked in more than one region. There was a wide spread of responses from across the country. Some 31% ($n= 91$) of respondents practised mainly in the North of England, 29% ($n= 87$) in the South, London accounted for 72

respondees (24%), and 16% worked mainly in the Midlands. We had 16 responses from Wales (5%) [Figure 2]



6. **An overwhelming majority of those who responded to the survey, 92.5% (n= 275) had experienced a shortage of medical experts in their cases. It was described by one respondent as a “looming crisis”**

7. Respondees were asked to indicate in which medical discipline a shortage had been experienced and the geographical area. The results are expressed as a % of the overall national %. [Table 1]

Role	North	South	Midlands	London	Wales	England and Wales
Child / child and family psychiatrist	21.89%	17.17%	9.43%	13.80%	4.38%	66.67%
Child / child and family psychologist	21.89%	17.17%	10.10%	12.46%	3.70%	65.32%
Adult psychiatrist	11.78%	10.10%	5.05%	8.42%	1.68%	37.04%
Adult psychologist	1.68%	1.68%	0.34%	1.68%	0.34%	5.72%
Consultant dermatologist	2.69%	2.36%	1.35%	1.35%	0.34%	8.08%
Consultant ENT surgeon	0.34%	0.67%	0.34%	0.67%	0.34%	2.36%
Consultant endocrinologist	3.70%	4.38%	2.36%	2.69%	0.34%	13.47%
Consultant general surgeon	1.01%	2.69%	0.34%	0.34%	0.34%	4.71%
Consultant geneticist	6.06%	5.72%	4.04%	3.70%	0.67%	20.20%
Consultant haematologist	7.41%	6.73%	4.38%	3.37%	1.35%	23.23%
Consultant neonatologist	7.41%	4.04%	2.02%	3.37%	0.34%	17.17%
Consultant neurologist	11.11%	5.72%	4.38%	4.04%	2.02%	27.27%
Consultant neuroradiologist	14.14%	12.79%	6.06%	8.08%	2.36%	43.43%
Consultant neurosurgeon	12.46%	7.07%	3.37%	5.72%	1.35%	29.97%

Consultant obstetrician	1.35%	2.02%	0.34%	0.00%	0.00%	3.70%
Consultant ophthalmologist	7.74%	6.40%	2.02%	2.36%	1.35%	19.87%
Consultant paediatrician	23.57%	16.50%	9.43%	12.46%	4.71%	66.67%
Consultant pathologist	4.04%	4.38%	0.34%	1.68%	0.00%	10.44%
Consultant plastic surgeon	0.67%	0.67%	0.34%	0.34%	0.00%	2.02%
Consultant radiologist	14.48%	13.47%	8.42%	9.09%	2.69%	48.15%
Consultant toxicologist	3.03%	1.35%	0.34%	0.67%	0.00%	5.39%
Risk assessor	10.44%	8.08%	4.71%	7.07%	2.69%	33.00%
Other	2.36%	1.68%	0.34%	2.02%	0.67%	7.07%

8. The main shortages identified by the lawyers which were consistently reported across the country were:

- Child and family psychiatrists and psychologists (67% (n= 198)/65% (n= 194))
- Paediatricians (67% (n= 198))
- Radiologist and neuroradiologists (48% (n= 143))/(43% (n= 129))
- Neurosurgeons (30% (n= 89))
- Ophthalmologist (20% (n= 59))
- Haematologists (23% (n= 69))
- Neonatologists (17% (n= 51))
- Geneticists (20 % (n= 60))

9. A shortage of child/child and family psychiatrists and psychologists was widely reported throughout the country. As Table 1 demonstrates, adult psychiatrists too were in short supply across England and Wales (37% (n=110)). Risk assessors were also identified by a wide number of respondees (33% (n=98)) to be limited across the country. These experts are often considered to be “necessary” at the “welfare stage” in public law proceedings and in assisting the court in providing evidence as to mental illness, personality disorder, attachment issues and risk to a child. This shortage of experts self-evidently has significant implications; it is usually an assessment that cannot be undertaken by another professional within the proceedings.

10. Equally worrying is the picture painted, countrywide, of those experts who are more likely to be instructed at the fact-finding stage of public law proceedings.

11. Whilst by no means in every case, it is not unusual, in a non-accidental head injury case to require the joint instruction of a Consultant Neuroradiologist, Consultant Paediatrician and Consultant Ophthalmologist. Shortages across the country have been identified in each discipline. It means it is overwhelmingly likely that there will be difficulty in finding at least one such expert in a Non-Accidental Head Injury case. One respondee stated that it was their perception that “*Most of the ophthalmologists have*

stopped taking work.” “There is only one neuroradiologist in the north and one in the south”.

12. Consultant Paediatricians are routinely considered by the court as necessary in cases involving Non-Accidental Injury Table 1 confirms that shortages were identified countrywide. 23% ($n= 70$) had experienced a shortage in the North, 16% ($n= 49$) in the South with 12% ($n= 37$) in London. The Midlands and Wales fared little better (9% ($n= 28$)/5% ($n= 14$)).
13. Consultant radiologists are instructed routinely in cases involving fractures, they were described by one practitioner as “crucial” in a Non-Accidental Injury case. The data shows that countywide 48% ($n= 143$) of respondees considered there was a shortage, the North (14% ($n= 43$)) and South (13% ($n= 40$)) suffering most clearly.
14. There is a significant shortage of experts who assist the court, often, with diagnostic testing: haematology, endocrinology and geneticists. Their expertise is often called upon by experts already instructed within the proceedings who seek further or different tests. We see this very often in our cases. The data is particularly troubling. 23% ($n= 69$) reported a shortage in Consultant haematologists; the North being in particular short supply. 20% ($n= 60$) reported a shortage in geneticists – the North (6% ($n= 18$)) and South (5% ($n= 17$)) being particularly affected. Consultant endocrinology was found to be lacking (13% ($n= 40$)) across the country, in particular the South (4% ($n= 13$)).
15. Across the country and across disciplines shortages were identified. Wales fared best but still significant gaps in expertise across the medical spectrum were noted.

The Impact

16. Respondees identified that the inevitable impact of such shortages was delay and increased costs. Respondees commented that it “*Has made it very difficult and in some cases impossible to conclude cases within 26 weeks*”, it meant “*Delay and increase in costs. Often experts refuse to accept instructions at legal aid rates and if the Legal Aid Agency refuses to pay the additional costs, the local authority will invariably bear these costs*”. One practitioner set this out clearly:

“I have one case currently standing adjourned to await prior authority for funding by the LAA. If the LAA refuses prior authority then there will be further delay whilst the LA process is undertaken to see if the LA will fund the shortfall. If it refuses there will be a delay (currently of three months) whilst an expert who is available and prepared to work at LAA rates is instructed. In real terms it means the difference between permanency planning being decided for a baby in September or December 2019.”

Another said:

"Funding is a real issue in most cases - not simply the overall payment but the delays in receiving consent to fund the report of the expert for Public Funded parties. This creates significant practical problems with timetabling".

"2 cases have been delayed because of the lack of radiologists/neuroradiologists who are willing to report at legal aid rates. Those that are willing have a backlog of work and cannot report within the 26 weeks causing the timetable to be extended. There are a number of local child and family psychologists who are willing to report at the appropriate rates but again a backlog of work sometimes means the timetable has to be extended in public law proceedings and private law proceedings become protracted which delays the resumption of contact between parent and child..."

17. One respondent states that *"We recently were unable to find a paediatric radiologist. A case in June 2018 had a radiologist being able to report in November 2018"*. This was something of a theme in the narrative responses: *"We searched the length and breadth of the country looking for a paediatric radiologist without success and two case management hearings had to be adjourned because no expert could be identified. Children were subject to ICOs for an additional 4 months with no progress"*. Another stated *"we are unable to identify any Consultant Paediatricians who will accept work and can report within the 26 weeks, resulting in a number of cases having to be extended."*
18. Example after example was given where a shortage of experts was impacting directly on the timetable for the case. One respondent stated that *"whilst it can be difficult to identify an expert within timescales, I have not had a case that was unable to utilise an expert"*, another said *"Case today: hospital clinicians approached to provide overview in a bruising case, having undertaken such work before - said could no longer assist in this way. Of about 10 independent experts then approached or considered, all but I were either recently retired, unresponsive or too busy. The one who has agreed has pushed the case timetable back by 6 weeks, as unable to report sooner"*.
19. Concerns were not limited to public law proceedings. One respondent reported their experience that in a private law children case (not publicly funded) where *"the court wants expert adult psychiatric evidence provided in 8 weeks, the experts I have contacted have all said that they would struggle to produce a report in that time frame and the costs estimate if in the region of £5,000...The parties can't afford the report which won't be released until paid and if instructed the burden would be on my firm to pay for the report if the parties failed to do so"*.
20. There were concerns that the pool was small, *"shrinking"* and that *"There is a real lack of younger members of these professions who are willing to undertake such work. This will only serve to exacerbate this problem over the next few years as the existing experts retire"*. This was reiterated by others *"Experts of quality do not seem to be given the*

time or the encouragement to advocate to younger colleagues the advantages of providing forensic evidence.”, “good experts (are) retiring and not being replaced.”

Reason for the shortage?

21. We gave respondents a choice of answers as to the perceived barriers to medical experts in undertaking medicolegal work. They were able to pick five as being the most applicable to their perception. Some respondees did not know the reason, they commented that *“I don’t know why they aren’t doing it anymore. We just make enquiries and are told no”*. Of those who were able to give reasons for the perceived shortage, Table 2 below demonstrates:
22. **84% (n= 249) of respondents considered that the shortage was due to medical experts being unable/ unwilling to work at the prescribed LAA hourly rates.** Over 100 people in the narrative responses considered the issue of fees to be the main, or part of the problem. One stated *“The family court cannot rely upon the commitment and goodwill of specialists to ensure that the system continues to function in the face of continued cuts.”*
23. One respondee stated *“Most experts”* or *“many consultants”* approached were *“simply not prepared to do work at LAA rates”*, *“Almost without exception medics are not willing to undertake work at rates prescribed by legal aid agency leaving shortfall to be met by local authorities”*. Another stated *“Experts reporting in most areas of expertise will not work to legal aid rates. The delays in seeking prior approval can add weeks/months to the timetable. If prior approval isn't received, the instruction only proceeds if the LA pays the shortfall”*.
24. It was reported that *“Good experts are not willing to work at LAA rates causing long delays. In a recent case concerning a baby with multiple skull fractures sustained in January 2019 the only expert radiologist (out of 10 contacted) who would undertake the work at LAA rates could not report until August”*. Another respondee stated *“Experts which were previously willing to do work within LAA rates are now stating they will only do work above that. In some cases where experts are clearly necessary, and in order to complete a case within a reasonable time the LA have ended up paying the excess, it simply shifts the problem from LAA to Local Authority meeting the shortfall”*.
25. This was a consistent theme in responses:

“Local Authorities are constantly being required, out of extremely stretched budgets, to meet the shortfall in fees or hours spent above those allowed by the LAA”. , further that *“The main issue is medical experts who are unwilling to work at LAA rates and/or hours. This leads to additional court time being used arguing about costs and the practice of the local authority being asked to “top up” the costs. Topping up has become routine and is clearly not what was intended when the rates and hours cap was introduced. Invariably the court*

decides that the LA should top up as it has no other recourse.” , with the overriding view “Why should local authorities be expected to pay more?..”, “Physician instructed charging considerable hourly rate over LAA rate and LA having to bear £5000 shortfall.”

26. One person considered that: *“The payment of such fees has a direct impact upon the finances of LAs and their ability to fund other services for children in an already overstretched system”*.
27. **40% (n= 119) believed that the inflexibility of timetabling by the court (26 weeks led to the shortage)**, this led to respondees stating that *“I am aware of an (eminent) paediatric neuroradiologist indicating that the demands placed by the current timetables for resolving these cases is unrealistic. His concern is that he gives realistic timescales for doing work and then receives a court order directing an earlier report.”*. One practitioner stated, *“Court imposing timeframes that are too short meaning experts were not available to commit to the work as they could not work to the timescale”*. Others stated that expert witnesses do their best to comply with the court timetable but there needed to be discussion with individual trusts to support the work and allow time.
28. **39% (n= 115) perceived that medical experts were simply not interested in the work.**
29. **35% (n= 103) considered that a concern about adverse criticism by a judge or critical cross examination had limited the pool of experts.** Over 20 respondees commented on this in their narrative responses. One respondee reported *“I have been told (anecdotally) of a well known expert radiologist and well known expert paediatrician who have apparently each said that they would be unwilling to take any further expert witness work after they each had a bad experience in court - under cross examination and feeling criticised by a judge”*. Another reported that *“Two close friends who would be strong candidates to undertake expert work for court have told me the rates do not compensate for the poor treatment they perceive that experts get in the Family Court. They tell me this is a widespread view amongst medical clinicians”*.
30. Others reported that *“In another case a Paediatric radiologist refused to take on any further new instructions following judicial criticism of her evidence.”*; another stated *“We also lost an expert frequently instructed in this area following a particularly brutal cross examination”*. One said, *“The consistent reason given is that the hourly rate on offer combined with critical cross-examination/criticism from the judge do not make it a worthwhile exercise”*.
31. Another stated

“I am aware anecdotally that experts are becoming very wary of criticism from the courts. I am aware of a number who no longer take on legal aid work because of the rates/amount of reading/lack of preparation time within the 26 week timetable but of those who continue to do so, there are some who are very reticent about taking on legal aid cases because they are concerned about criticism from judges (not least following recent judgments criticising experts

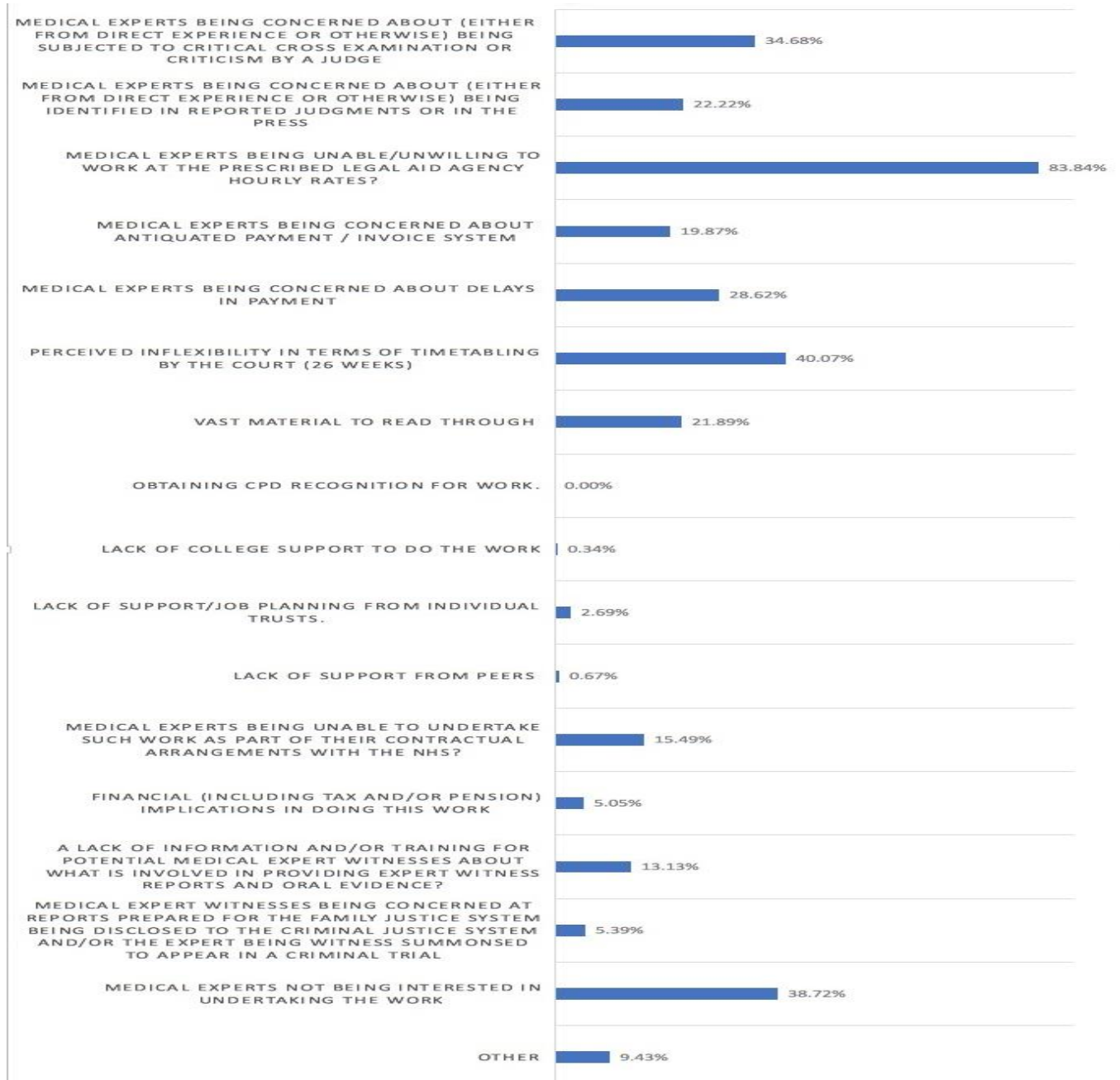
for not reporting on time, which are - to be frank - deeply unhelpful in a climate where finding a good expert willing and able to report within the 26 week timetable can be a real achievement)".

32. **Criticism in the press was another perceived reason for the shortage** (22% (n=66)). One respondent thought that *"Given that judgments are now longer anonymised, experts are also concerned about criticism in the press (especially in relation to issues that are hotly contested in the media, such as transgender issues). In my experience, experts tend to be more willing to become involved in such cases if they feel that the judge in question is likely to give a balanced judgment: experts are perceived to have been the focus on unfair criticism in some recent judgments, particularly when lawyers are not necessarily held to the same standards in relation to professionalism and timekeeping.*
33. **28% (n=85) were of the view that delays in payment led to shortages.** One respondent stated *"Otherwise the main issue is those who are just fed up with working for the Legal Aid Rates and/or having the hassle of the invoices being split and waiting for payment etc"*. Another stated *"The Legal Aid Agency is very difficult to deal with when experts fees/hours are outside guideline rates. For instance, in a case expected to conclude within 26 weeks, the LAA took 8 days to refuse a prior authority decision and when asked to review the decision I was informed that it would take up to 22 days. Experts being kept in limbo for this amount of time is unreasonable."*, *"A Consultant Radiologist has recently told us that he is no longer willing to undertake work for family cases due to delays in payment. He confirmed that the delay was not on the part of the local authority but of the legally aided parties"*.
34. **Other reasons were identified. There was a perceived concern about reports being used in the criminal justice system (5% (n= 16)),** it was said that *"There is one consultant paediatric ophthalmologist who explicitly says that he will no longer work in certain geographical areas because the CPS have sought to rely on a report that he produced when it was disclosed from family proceedings without prior agreement or consultation. He puts a warning on all reports that if it is disclosed into and relied upon within criminal proceedings he will stop taking further instructions in that geographical area."*
35. **There were concerns about the amount of material experts had to read (22%(n=65)).** *"The amount of material that an expert is expected to read in any set of family proceedings to give an accurate opinion on any case within legal aid rates is unreasonable for any professional subject to questioning through the family and potentially criminal courts. The inflexibility and time constraints for NHS employed experts to complete reports to high standards is extremely difficult and must dissuade a number of experts"*.
36. Our legal practitioners did not consider that a lack of College support (0.34% (n= 1)), a lack of support from peers (0.67% (n= 2)) or obtaining Continuing Professional Development recognition for the work (0%) significantly affected the shortage.

Similarly, only 15 respondees considered that financial (tax/ pension) implications of doing this work accounted for the shortage (5%), and only 3% ($n= 8$) thought that a lack of support of job planning from individual trusts was to blame.

37. A summary of the data is set out below [Table 2]: -

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38. We asked if respondees were aware of medical specialists who were unwilling to become expert witnesses or provide expert opinion evidence (as opposed to purely factual material such as medical records or material). Just over half of those who responded to this question, answered in the affirmative. Some respondees stated that such clinicians “*refuse to be instructed as a SJE [Single Joint Expert], saying they have*

neither time nor the training to provide an expert report. To avoid delays in final hearings, I am increasingly having to cross examine the treating clinicians at a longer IRH and then advocates are required to agree a note of the evidence. ...” Others stated that “treating clinicians are unwilling to give opinion evidence they have informed us they do not have the correct insurance...” Many reported treating clinicians were “reluctant” to be instructed as an expert witness. Paediatricians in particular were singled out by some.

39. We also asked respondees if they were aware of medical specialists who will provide a report as a treating clinician but are then not willing to participate in experts’ meetings or to give oral evidence to the court. This was a regular experience of our respondees. Over 100 people stated they were aware of this (38%). One stated that treating clinicians were “reluctant to be drawn on their initial findings or to attend court to give evidence” It was described as a frequent problem. Some had experience of clinicians stating they did not give permission for their reports to be used in court. Some cited the impact on their “professional commitments (e.g. NHS clinics which have to be moved as witness timetables change/run over at short notice)”.

40. Others said they had experience of treating experts being very willing to come to court to give evidence on factual issues only.

Decline in quality

41. We asked if respondees had noted a decline in the quality of expert reports. 54% stated that they had. We sought to better understand if this was a countrywide problem and whether one discipline more than another was affected. The data revealed the following trends [Table 3]:

Role	North	South	Midlands	London	Wales	England and Wales
Child / child and family psychiatrist	6.7%	6.4%	1.7%	6.7%	0.7%	22.2%
Child/child and family psychologist	10.4%	12.1%	3.0%	7.4%	0.7%	33.7%
Adult psychiatrist	4.0%	5.7%	2.0%	6.7%	0.3%	18.9%
Adult psychologist	1.0%	0.3%	0.3%	1.0%	0.0%	2.7%
Consultant dermatologist	0.0%	0.0%	1.0%	0.0%	0.0%	1.0%
Consultant ENT surgeon	0.0%	0.3%	0.0%	0.0%	0.0%	0.3%
Consultant endocrinologist	0.0%	0.0%	0.0%	0.3%	0.0%	0.3%
Consultant general surgeon	0.7%	0.3%	0.3%	0.3%	0.0%	1.7%
Consultant geneticist	0.7%	0.3%	0.3%	0.3%	0.0%	1.7%
Consultant haematologist	0.0%	0.3%	0.3%	0.3%	0.0%	1.0%
Consultant neonatologist	0.0%	0.0%	0.0%	0.7%	0.0%	0.7%

Consultant neurologist	1.3%	0.3%	0.3%	1.0%	0.0%	3.0%
Consultant Neuroradiologist	1.7%	1.0%	1.0%	0.7%	0.0%	4.4%
Consultant neurosurgeon	1.3%	0.3%	0.0%	0.3%	0.0%	2.0%
Consultant obstetrician	0.3%	0.0%	0.0%	0.0%	0.0%	0.3%
Consultant ophthalmologist	1.0%	1.0%	0.0%	0.7%	0.0%	2.7%
Consultant paediatrician	12.5%	5.4%	2.7%	4.7%	1.0%	26.3%
Consultant pathologist	0.7%	0.7%	0.0%	0.3%	0.0%	1.7%
Consultant plastic surgeon	0.7%	0.0%	0.3%	0.3%	0.0%	1.3%
Consultant radiologist	3.0%	2.4%	0.7%	0.7%	0.0%	6.7%
Consultant toxicologist	0.0%	0.3%	0.3%	0.0%	0.0%	0.7%
Risk assessor	3.0%	4.4%	1.3%	2.7%	1.0%	12.5%
Other	1.0%	1.0%	0.3%	0.3%	0.3%	3.0%

42. Child/Child and family psychiatrists/psychologists and paediatricians were most frequently mentioned by respondents to this question, and as before, although Wales fared better than the rest of England, there were concerns in all areas of the country and across disciplines. Others commented on the *“extremely capable and competent experts reporting and the quality of their reports has not reduced. The problem is obtaining a report from them within timescales as they are invariably very much in demand”*.

The Solution?

43. We asked our respondents what they considered could be done to encourage more experts to assist the courts. There were a number of themes evident in the narrative responses received, and in line with data as to the perceived reasons for the shortages.

44. **Fees:** many responses were encapsulated as follows: *“The family court cannot rely upon the commitment and goodwill of specialists to ensure that the system continues to function in the face of continued cuts”*. Many respondees considered funding was the main issue. There were a number of calls to *“increase rates”* to *“higher rates”*. That there had to be changes to the LAA rates. There should be *“proper pay”*. The current rates were described as *“not fit for purpose for experts”*.

45. In the absence of a rise in fees, other respondees considered that time should be made available to practitioners to undertake the work as **part of their NHS duties**. Others suggested that *“Perhaps the Royal Colleges could be approached to form a Faculty of Expert witnesses and come to some arrangement with the NHS that in return for an increment on salary members of the Faculty would provide expert evidence as part of their NHS contract on the basis that a proportion of the experts fee is paid to the NHS”*,

that there needed to be “discussions with individual trusts to support the work and allow time”, that their “NHS contracts should allow for them to be expert witnesses in family matters”, “The principal obstacle is now the T and Cs imposed by Heath Trusts who do not support their consultants doing this work. This requires addressing at a strategic level with the DoH”.

46. **Criticism by the judge/hostile cross examination.** 35% (n= 103) of respondees had identified this as a reason for the shortage in expert evidence and this was a theme in the narrative responses. As one respondee stated “*Experts at the top of their field are used to being valued and respected. This contrasts with the treatment they sometimes receive from the court. The Family Justice system could work to correct that*”.
47. A number commented upon the need for a reduction in critical judgments of experts. Time and time again, respondees cited what they considered to be unnecessarily critical judgments which will put others off taking on work in the family court. A recent judgment was cited by a few respondees in particular. One describing what they considered could be seen by healthcare professionals as a “*climate of criticism at court*”. It was felt judges should do more to ensure that “*those charged with cross examination are not allowed to (a) barrack the witness and (b) interrupt the witness*”
48. **Training:** respondees considered that “*There needs to be proper support, nationally and locally, to identify best practise, to provide exchange of information and training and to encourage clinicians to see this as a core part of their work.*” Further:
- “*there needs to be encouragement to them to train juniors to begin preparing for such work*”
 - “*professionals who are interested in providing expert court reports (should be allowed) to sit in on family courts to understand the process and how expert evidence is handled*”.
 - There should be “bespoke training” about the court process
 - There should be sharing of good examples of expert reports
 - There should be liaison between the professions
 - *Family Justice Boards should encourage sitting in and experience of courts to reduce anxiety*
 - There should be Awards to *recognise contributions to medico-legal matters*
 - There should be a *dialogue with the relevant College and Medico-Legal society.*
49. Some respondees spoke of some success with some local training initiatives. In particular, some referenced the training course with the Royal College of Psychiatrists. One respondee spoke of setting up a local group which encouraged the police and the local authorities to have closer liaison about the choice of experts so as to avoid the duplication of the work within the Family and Crown Court. There was mention of the Northern Circuit running an expert witness course in which young barristers learn advocacy skills with young healthcare professionals as their 'witnesses'. One had experience of an initiative in Liverpool where the court allowed hospital doctors employed in roles involving child protection to observe public law family court proceedings. There was reference to a local interdisciplinary group in Manchester

including experts; there was local Judiciary engagement with experts. One respondent considered there should be regular family justice days to which experts would be encouraged to attend.

50. **Expectations;** practitioners felt we had a duty to support experts by “*clearer and less onerous instructions*”, to consider what papers the expert really needs, there needs to be “*an understanding about what the court expects from the experts*”. Although others considered that paring down the instruction “*in an attempt to save money... means it is not possible for a professional to maintain integrity and professionalism if they accept the instruction*”, on this theme one responded that “*I have recent experience of an ophthalmologist who was unwilling to accept instructions if the court would only permit a concise report (i.e. the instructions included that the expert should not repeat all the evidence that he had read etc when providing his report). He would only accept instructions on the basis that he was permitted to produce a report in the format that he professionally thought he should...It did seem to me that the courts are running a risk that in trying to cut down the volume of papers (and repetition) that can occur when there are a number of expert reports, we are not permitting the experts to do their job in the way that they would professionally wish to do, and thus potentially putting some experts off doing the job at all*”. One respondent commented that “*Many reports take the same, medically orthodox points, about causation and timing of injuries and it ought to be possible to develop a baseline or template of currently accepted medical knowledge which builds in any well founded differences of medical view and which could then be utilised as a starting point for the family court. If that could be done, a process of ordering shorter, tighter reports focusing on the facts of the case might be possible, with the caveat that the parties could put additional written questions challenging the views expressed (as now)*”.
51. One practitioner stated that “*more could be done to illustrate to medical professionals how their reports are a valued and essential part of the justice system*”. A number of respondents were clear that judgments should be sent to the expert with some feedback. It was also felt there could be greater use of video link.
52. **Others said there should be less timescale pressure.** Judges should not impose “*timetables which cause them difficulties in also fulfilling their obligations to their "day" job.*”, “*The limits on the hours that can be spent, and the rate per hour does not encourage good experts into the field. It's becomes not financially viable for them to do it, or reduces the incentive for them to want to put themselves through the tough processes and timescales of the court process*”.
53. Some considered it would be useful to have a centralised register of accredited court experts.

Commentary

1. Barriers preventing health professionals from providing expert witness work are not necessarily a new phenomenon. The shortage of witnesses has been discussed within the literature elsewhere, with solutions for practice proposed⁴, many of which mirror the findings from the survey presented here. However, arguably, this working group presents the first time that a number of Medical Royal Colleges and the Family Court have come together to develop joint health and legal solutions to address the problem.
2. Results from the medical and allied health survey have identified resource pressures preventing health professionals from conducting expert witness work (namely: lack of time, money and support). It is necessary for the importance of this work to be communicated to health professionals and their employers to motivate and support individuals. The survey identified that there is an interest amongst health professionals, who recognise the benefit in improving outcomes for children and young people (“*I have a deep interest in this meaningful work and so I am going to continue doing it*”), but the barriers need to be addressed if health professionals are to meaningfully engage in future expert witness work. Furthermore, it should be encouraged that providing expert witness work improves discipline and practice, which professionals can bring back to the clinical setting as a form of quality improvement.

Existing guidance and support

3. It is important to note that there is existing guidance for health professionals to support them in understanding the role of expert witnesses:
 - **RCPCH & Family Justice Council.** ‘Paediatricians as expert witnesses in the family courts in England and Wales’ (August 2018)⁵
 - **Academy of Medical Royal Colleges.** ‘Acting as an expert or professional witness: Guidance for healthcare professionals’ (May 2019)⁶

Furthermore, the Consortium of Expert Witnesses exists to support health professionals providing expert witness work and should be involved in future work.

4. Best practice example – Northern Heads

The “Northern Heads” safeguarding peer-review meeting was established in 2017 by the child protection multidisciplinary team at Royal Manchester Children’s Hospital, building on the success of their previous quarterly joint peer review sessions with Alder

⁴ Oates, A. et al. (2019) ‘Shortage of paediatric radiologists acting as an expert witness: position statement from the British Society of Paediatric Radiology (BSPR) National Working Group on Imagine in Suspected Physical Abuse (SPA)’, Clinical Radiology.

⁵ <https://www.rcpch.ac.uk/resources/expert-witness-guidance>

⁶ https://www.aomrc.org.uk/wp-content/uploads/2019/05/Expert_witness_0519.pdf

Hey Children's Hospital, Liverpool. The meeting is a cross - speciality peer-review session across specialties (predominantly paediatricians, radiologists and neuroradiologists, but with contribution from ophthalmologists and neurosurgeons) for tertiary centres across the North of England and Scotland, with participation from Manchester, Liverpool, Birmingham, Sheffield, Leeds, Newcastle and Glasgow.

5. The day long meetings are held quarterly. Each centre is invited to present a selection of cases of children investigated for suspected inflicted head trauma. The clinical presentation, radiological imaging, medical photographs along with the conclusions from the treating clinician's written report are collectively reviewed. The setting allows for open, constructive discussion and challenge in a supportive environment between peers and colleagues.
6. All specialties with an interest in child protection are encouraged to attend and the meetings have been well-received from all attending specialties from the senior trainees to the very senior consultant.
7. While the purpose of the meeting is not primarily to encourage our colleagues to take on expert reports for the Family Court, we believe the discussion of complex neuro-trauma cases in a non-judgmental and open forum is a firm foundation for promoting and developing sound practice and for supporting each participating consultant's practice development. Ultimately we believe this can only benefit the care provided to the child and their family, and may instil confidence to those medical professionals considering becoming a medical expert for the family court and allow them to take the next step. The knowledge that a court appointed, jointly instructed expert is an active participant in specialist peer review of this nature, can provide a degree of assurance to the court that the expert's report will be in keeping with mainstream clinical opinion in the field.
8. Meetings such as "Northern Heads" require minimal funding, the success lying in the enthusiasm of the participants to actively engage in the process because of the benefit and professional support it provides them in this challenging area of paediatric practice. We believe this meeting is an exemplar which could be replicated in each region in the country.
9. Those responding to the survey reported a "crisis", with a "creaking" system. Where medical evidence is at the heart of the case "relying on poor quality or insufficiently experienced experts" (or we would add not being able to instruct an expert) can result in real injustice. The impact on the children who are the subject of the proceedings and the families before the court "is irreversible".
10. The legal members of the working group broadly had the same views and experiences as those who responded to the survey. Family Courts often require experts to assist in determining complex issues and there is a general consensus in the legal profession that those experts are increasingly disenchanted with the work. The volume of paperwork involved in writing reports and the tight timescales imposed by the court is a significant disincentive. These issues are exacerbated by rates of pay, the cumbersome process of

securing their remuneration and what some perceive to be the hostile environment of the family court.

11. The responsibility placed upon experts in cases is high, albeit the judge is the individual who decides. The consequences of 'getting it wrong' can be severe, for the child or children concerned, or indeed for the expert. The legal group had experience of experts pointing out to them that there was very little incentive to take on the work, and risk being 'named and shamed' sued, or investigated by the GMC or other regulators.
12. All these matters have a direct bearing on the available pool of experts.

Treatment of experts

13. We noted that some 35% of the respondents to the legal survey considered that the pool of expert witnesses had narrowed owing to a concern about adverse criticism by a judge or critical cross examination. There was concern (albeit anecdotally), by lawyers, that experts feel poorly treated by the court, and that they should not be "barracked" and "interrupted". That was confirmed by the medical survey which suggested that some 25% of the respondents felt that such treatment was responsible for a shortage. Anecdotally there is a growing increase in experts fearing criticism, not only from the lawyers but from the very people they assess. This adds to an ever-growing reluctance to accept instructions.
14. The symposium considered this issue in more detail. Some medical professionals expressed surprise as to the level and type of questioning in the family court; others were more sanguine about their experience noting the importance of the issues at stake. The lawyers pointed out that advocates must be able to test the evidence and that they have a legal duty to their client. The issues at stake in family proceedings could not be more important, and therefore a forensic analysis of expert evidence is only to be expected. Consequently experts who provide reports for family proceedings should anticipate that their work will be scrutinised, and that questions will often be put to them which seek to explore and sometimes directly challenge their approach, conclusions and opinions.
15. We consider that more could be done to prepare expert witnesses. There was widespread support from across the respondents for bespoke training for experts about the court process and the giving of evidence, whether as an instructed expert or a professional witness. The purpose and importance of giving such evidence needs to be emphasised to the Royal Colleges, NHS trusts and all the professional bodies involved and there should be a proper budget for such training.
16. Information packs could be created to assist them to understand the court process better. Ideally the pack should be prepared in consultation with experts who have significant experience of giving evidence.
17. We believe that training would, amongst other things, assist in preparing experts for the realities of giving evidence and the nature of the forensic and inquisitorial process in family proceedings which may not otherwise be fully understood. We are particularly conscious that expert witnesses are in short supply, the demands on their time are great and they increasingly feel the pressure of the 26 week deadline as has been found in our survey. That is exacerbated by the frequency with which experts are now, more than

ever before, called upon to give oral evidence. For those just starting out in their medico legal careers, there is little time between cases to reflect and hone their skills.

18. We consider that the Family Justice Council should be invited to extend the mini pupillage schemes for both professional and expert witnesses. Currently there is a scheme open to specialist registrars but there is variation across the country; it operates principally in the Royal Courts of Justice in London. It is felt that this scheme should be rolled out nationally so as to foster a transparent approach between experts and advocates and to capture a wider variety of experts who work with children. This would increase understanding of each professional's working environment, to address misconceptions about respective roles in practice. The mini pupillage scheme should be revived and standardised across England. It should be directed at senior trainees but also, perhaps most importantly, junior consultants who have a few years of experience working at senior doctor level. We believe it is important to recognise, that a fundamental aspect of being a "good" doctor is having seen and being continuously exposed to large number of varied cases. This can only be achieved with time/experience and is essential in providing a considered and sensible opinion to the Court.
19. Likewise the development of a scheme to allow legal professionals to experience medical practice in a paediatric or intensive care unit would promote better understanding amongst the Judiciary and lawyers of how medical professionals practice.
20. Whilst it is recognised that the Family Justice Council might wish to set a national standard and uniformity of approach to the regional FJCs in each respective geographical area; there ought to be a mechanism whereby the communication works both ways. The regional practices should be able to communicate aspects relating to experts in their particular region to the central FJC. The sharing of information in this way could lead to an improvement in services, implementation, and statistical information gathering.
21. So far as advocates are concerned, the group considered that the FLBA, ALC and Resolution should be encouraged to offer training to their members as to the cross-examination of experts. This comes at a time when training is required for the treatment of vulnerable witnesses in the family jurisdiction. It is perhaps a welcome point to consider both.
22. Peer support networks both within the medical profession but also between legal and medical professions would also be a valuable addition to the range of solutions which would support both existing experts but also new entrants. Structures for peer support and mentoring are more commonplace in the medical professions whereas in the legal profession after the completion of mandatory training for new practitioners there is no formal peer support or mentoring albeit much occurs informally. Support from the legal professions and the Judiciary to support the establishment of peer support networks and mentoring opportunities for medical and allied health (particularly psychology) expert witnesses perhaps through the Regional FJC Committees. The network should enable peer review and anonymous space to discuss cases confidentially, which will enable a mechanism for medical professionals to receive appropriate and timely feedback from

the Judiciary on cases. The network should also provide links to training and job shadowing schemes.

23. Existing regional safeguarding peer review networks should be developed to include multi-professions and lawyers. We highlight the exemplar model of the “Northern Heads” peer-review meeting, originally established at Manchester and Alder Hey Children’s Hospital. This meeting provides the opportunities for a range of medical disciplines to discuss suspected cases of abusive head trauma in non-judgmental environment to aid learning and share experiences.
24. We believe there should be the means for a structured ongoing dialogue between the Family Court and representatives of medical and allied health experts to address issues that may arise and promote education. The establishment of regional bodies would be a sensible approach to mediate such a scheme.
25. In court, it is important that experts are treated with courtesy and respect (as all witnesses) and judges should intervene if they are not. This does not mean that an expert should not be challenged or that any gaps, inconsistencies or faults in his or her evidence should not be the subject of questioning, but there are ways of doing this without interrupting or being rude. Those in the legal group did not have personal experience of witnessing this, but it was raised by the experts themselves.
26. The group also believe that beyond setting out reasons why they accept or do not accept the evidence of an expert, judges should be slow to criticise the professionalism and expertise of an expert publicly without good reason. It is acknowledged that the judges are entitled to do this in a proper case, but bearing in mind the effect that calling into question an expert’s professionalism will have upon not only that expert, but the message it sends to other experts, such a power should be used sparingly and only if it is really necessary to do so.
27. Where a judge proposes to name an expert in their publicly available judgment, the expert should be entitled to see a draft of the judgment in advance of publication and have the opportunity to make representations to the judge. The representations should include any concerns on the fairness of the comments and whether they should be named, prior to any publication taking place. The current Transparency Guidelines of 16 January 2014 provide that experts be named in published judgments unless there is compelling reason not to.

The expert instruction

28. It is acknowledged that there needs to be an easier way of instructing experts especially when prior authority is required. Delay in payment or securing an expert can lead to an expert becoming unwilling to act again in the future. The recommendation is that one solicitor might be responsible for making the application on everyone’s behalf.
29. A number of experts commented upon the volume of paperwork they were sent to consider. It is obvious that the paper sent to them should be proportionate to the issues in the case, but there was understanding within the legal group that it is often difficult for advocates to have had the time to identify (from voluminous papers) what documents are relevant at the time the instruction is agreed. Counsel (particularly leading counsel) may only be instructed at the last minute. That being said, the blanket

sending of all the documents, including (for example) all police and third party (non-medical) material should be deprecated. The requirement that questions to experts need to be relevant and should be approved by the court where the expert is instructed should be strictly adhered to.

30. The working group notes that there are a number of agencies who provide a service of collating, organising and indexing medical records. This would be a more efficient use of medical experts' time and potentially have costs savings as the amount of time experts would need to give to organising the papers or identifying what they needed to read would be reduced. The hourly rate for this administrative service should be cheaper if performed by a service provider with experience in collating medical records than the hourly rate for a solicitor or consultant medical expert both in term of the cost of misapplied expertise and in terms of speed (so less hours needed). Medical experts should not be required to undertake what is a clerical administrative task. Solicitors leading the instruction of expert witnesses should not perform a task which is both clerical but requires familiarity with medical record keeping. It might also 'free-up' time for experts which would make taking on such work more attractive or allow them more time to conduct the analysis itself.
31. It is also acknowledged that it is extremely difficult for complex public law cases to remain within the 26 week time limit. Some evidence will be available when the case commences but often relevant evidence is only filed once the proceedings are established. Additionally, it takes time for counsel to be instructed and for solicitors and counsel to master the paperwork. Strict time limits pursuant to Part 25 will only be realistic if the lawyers have sufficient time, once instructed, to carry out the task of identifying which papers should go to the expert (and can be more difficult than is sometimes appreciated), what experts are required, and what questions they should be asked. It may be that judges should recognise such cases as an early stage, and remove them from the 26 week track.
32. The thinking behind some of the specific recommendations below as to the court process was to focus upon the process by which experts are instructed, their subsequent involvement, the requests for further written work following any completion of their report, their involvement in resulting meetings and finally their giving evidence at trial. It was clear from the results of the survey that these issues, whilst not in the front rank of reasons for a declining number of willing participants were matters which had some impact upon involvement and yet were matters which were far more easily resolved.
 - a) To ensure only necessary documents were sent to the expert.
 - b) To dissuade experts from being asked a 'dripping roast' of questions at odd stages of the proceedings.
 - c) To allow a reasonable time for consideration and answering of questions, particularly to avoid requests to answer a question within a few days or even less.
 - d) To ensure that experts' participation is only where necessary and in accordance with the issues still requiring adjudication.

- e) To ensure that experts participate rather than attend unless clear reason for requiring the latter. Default position should be that (a) they are not required and (b) they participate rather than attend.
- f) To ensure that having fixed the timing of the expert evidence it is respected by all, including when attempting to maintain court business and maintain the through-put of cases through the courts.

The solutions essentially lay in allowing lawyers sufficient time to prepare, to adhere to the requirements of Part 25 and, wherever possible, enabling experts to participate in hearings rather than have to attend at court.

Payment

- 33. The group agreed that practicalities of how experts are paid are too cumbersome and cause delay. The LAA's guidance for expert witnesses should make it easier to obtain prior authority to instruct an expert. The process for prior authority should be reviewed as to whether it is needed in some circumstances and the process should be simplified. At the least, one prior authority approval made by one nominated party's solicitor should apply where an expert is jointly instructed, and the expert instructed should only have to issue one invoice to obtain payment. It should be possible for one prior authority application to be made on one occasion in relation to the instruction of multiple experts.
- 34. Issues around the numbers of hours allowed by the LAA for experts should be addressed, including for some larger assessments and for dealing with any questions, experts' meetings or other work further to the filing of experts' reports. Preparation of the main report and then additional work is to be expected.
- 35. Some of the lower legal aid payments for experts, particularly the removal of the London/non-London differentiation, should be reviewed. We are aware of concerns about legal aid remuneration rates for both experts and lawyers working in the family justice system.
- 36. The working group notes that as a direct result of the Survey and the feedback received that discussions have taken place between the Legal Aid Agency and solicitors bodies which has resulted in progress being made on legal aid matters.
 - There will be a new guidance document on the remuneration of experts (the current version is from April 2019⁷). The revised version will clarify a number of matters.
 - It has been agreed that one party alone can apply for prior authority and the result will apply to all the legal aid certificates in the case as long as those details are provided in the lead application.
 - There is to be a list of commonly used experts who are not included in the statutory instrument and the LAA won't expect a prior authority for those rates.

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/791497/Guidance_on_the_Remuneration_of_Expert_Witnesses_April2019.pdf

- The LAA does not expect an expert to issue multiple invoices so they issue one invoice with the details of all paying parties on it.

Other matters

37. A number of experts expressed concern that their reports would be disclosed between criminal and family proceedings, and having agreed to act as witnesses in one set of proceedings they found themselves required to give evidence in another. This may be something that should be addressed in the instruction and in training, but it is also vital to ensure experts are properly paid for all their work.

Supporting and Maintaining Change

38. The working group considers that there will be an on-going need for a body to oversee the implementation of the recommendations of the WG. Some of the recommendations are longer term which will involve a process of consultation, negotiation and implementation with stakeholders outside the umbrella of those involved in the working group for instance NHS commissioners, DoH, MoJ and LAA. Other recommendations where the process of implementation can begin immediately will need support in the implementation phase and monitoring, support on an on-going basis particularly with making changes from lessons learned.
39. The Family Justice Board was set up to improve the performance of the family justice system and to ensure the best possible outcomes for children who come into contact with it. The Board aims to take a cross-system approach to family justice and is jointly chaired by Ministers from the Ministry of Justice and Department for Education. Its members are senior stakeholders from across the family justice system. The Family Justice Council is a sub-group of the FJB who provide expert advice to the FJB and develop practice guidance for the family justice system. The working group considers the Family Justice Council (FJC) to be the most appropriate body to take on the function of supporting and maintaining change. As the body whose foundation is to promote inter-disciplinary working in family justice the WG's recommendations are perhaps a paradigm example of an inter-disciplinary function. The FJC also has administrative support which might be necessary. There would appear to be some overlap between the possible functions of the FJC and those of the Family Justice Board in respect of the FJB's remit in respect of the performance of the family justice system and its responsibility for making recommendations aimed at improving performance at national and local levels and the working group would suggest that some mechanism for liaison between the FJB and the FJC is considered. The FJB which is Chaired by Regional Groups could report annually to the FJC Sub-Committee who would then report annually to the FJC and FJB. A representative of the RCPCH or RCR or other Royal College could be co-opted onto that Sub-Committee.
40. Implementation on the ground of the training recommendations, including medical mini-pupillages, mentoring and feedback/discussion would best be done in our view at a local, probably regional level. The working group considers that setting up an entirely new structure would be over ambitious and that it would be preferable to make use of

some existing structures. The working group considers that some form of framework based on large regional areas would probably be the most effective approach rather than a be based on individual courts or NHS trusts. The logistics of smaller scale committees would be very difficult to set up and maintain. Regional committees on the other hand would in the WG's view be likely to be more manageable and to attract sufficient committed individuals to develop momentum and longevity.

41. Both the NHS and the Family Courts have some element of large Regional organisation.

Family Division Areas	<u>NHS Areas</u>
North (Manchester, Liverpool, Carlisle etc)	North West
North East (Newcastle, Leeds, Teesside etc)	North East and Yorkshire
Midlands	Midlands
Wales	<i>NHS Cymru</i>
East Angelia (Cambridge, Norfolk etc)	East of England
Western (Bristol, Portsmouth, Cornwall etc)	South West
London and Thames Valley	London
Kent, Surrey, Sussex	South East

There are 41 Sustainability Transformation Partnerships / Integrated Care Systems, which sit within these regions. These are responsible for: managing resources, delivering NHS standards, and improving the health of the population they serve. <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>

42. Local Family Justice Boards vary in their level of activity and functions but could usefully play a role in this regional committee. It is understood that some LFJB's already undertake some training responsibilities.
43. Although Family courts operate on a more local level with several DFJ's per Region a group of courts fall under the umbrella of a regional circuit with a Family Division Liaison Judge as the judicial lead for family justice.
44. Both the FLBA and Resolution have regional structures and those regional groups could be approached to provide professional representatives who would then be able to draw in their membership both to give and receive training.
45. The working group considers that the Family Division Liaison Judges (FDLJ) for each circuit might be best placed to Chair such regional committees. The working group appreciates the already extensive duties of the FDLJ. It might be that the FDLJ could

delegate some responsibility to another Family Division judge or a Deputy Family Judge. One of the functions of the FDLJ is supporting the effectiveness of the family courts and the implementation of the working group recommendation is likely to be an important element of improving the delivery of family justice.

46. Apart from FDLJ the Committees would require representation from Circuit Judges, District Judges and possibly Magistrates. The FLBA and Resolution could provide representatives for the legal profession. On the Medical side it seems to the working group that regional representatives from one or more of RCPCH, RCP, RCS, RCR and BPS or any other person who was considered a significant contributor in that region would be appropriate. Some form of system to engage or cascade information to all other interested medical colleges or other expert groups would need to be considered.
47. The Regional Groups with admin support from FJC (which would almost certainly be required) would be primarily responsible for:
 - a. Setting up and delivering training to experts and lawyers including mock trials and discussion forums for judges, experts and lawyers to meet and exchange ideas,
 - b. Setting up and delivering a medical mini-pupillage/Marshall's scheme to enable experts to attend court to experience medical experts in the court arena and possibly a reverse scheme to enable judges to visit a paediatric ward
 - c. Promoting inter-disciplinary respect and co-operation through promoting feedback from judges and lawyers to experts and vice versa and through mentoring and peer discussion of cases in an anonymous environment. It might be possible to consider some form of formal channel for feedback including where concerns were expressed by a judge about a report or evidence given as an intermediate step rather than matters being referred directly to the GMC.
 - d. Providing annual feedback to the FJC Experts in the family justice system' committee who in turn would report back annually to the FJC and perhaps the FJB.
 - e.
48. In the absence of administrative support from the FJC or FJB it might be that President of the Family Division's office and the Family Division legal assistants might support the Regional Committees. Meetings might be accommodated in the main family court for the region or within a hospital setting if such were possible.

Recommendations

1. A number of the recommendations we make maybe relatively easy to adopt in particularly as to how the Family Courts deal with matters such as the material provided to experts, the necessity for attendance at or participation in hearings and scheduling of expert evidence within a Witness Template. Even this would require a concerted effort from the senior Judiciary, a degree of training and joined up working with the legal professions. Other recommendation such as the creation of a structure to support training and mentoring and its implementation are more ambitious although we believe achievable. Others such as means and rates of payment will require buy-in by the Ministry of Justice and the Legal Aid Agency – although initial indications are so far positive. The creation of an environment in which expert work becomes embedded into NHS practice through Commissioners and Trusts in England, Health Boards in Wales and the Medical Royal Colleges is more far reaching although we believe is achievable and has benefits for the Commissioners and Trusts/Health Boards as well as the experts and the Family Justice System. It is important solutions within the gift of the Family Justice system whether via the Judiciary, the legal profession, HMCTS or the Ministry of Justice and the Legal Aid Agency are considered alongside those for Medical Royal Colleges, namely commissioners and service planners need to pledge their support for expert witness work in order for NHS employers to engage. RCPCH and other Medical Royal Colleges are currently seeking conversations with NHS England to discuss what these solutions could be.

Medical Colleges

2. Following analysis of the medical and allied health survey and discussion with colleagues at a symposium, it is important for Medical Royal Colleges to recognise the need to better support their members to provide expert witness work. The following recommendations are suggested (however, the authors are only able to comment for their respective Royal Colleges):

Recommendation 1

3. RCPCH and other Royal Colleges to create an online resource checklist for healthcare professionals, which details what is expected from expert witnesses. The content of the resource will be agreed by the Judiciary, to confirm that the knowledge, skills and expertise required of medical expert witnesses is standardised. Development of this resource would clearly outline the detail of the role, including (but not limited to): content of a court report, explanation of the Family Court, how to respond to a letter of instruction, how to track time spent on court cases. The content should be guided by existing education programmes and guidance. It is expected that this resource could be promoted among healthcare professionals to encourage more to become expert witnesses. RCPCH to share this resource with members, for example, through Paediatric Care Online (PCO). RCPCH to promote expert witness work through production of a webinar, which will be free to download for all health professionals.

Recommendation 2

4. Royal Colleges to increase awareness of existing training for healthcare professionals (e.g. RCPCH expert witness training) and further develop combined training courses between different specialties (e.g. paediatricians, neurosurgeons and radiologists). RCPCH should consider expanding their expert witness training to run more frequently throughout the year and explore the possibility of inviting other healthcare professionals. A specialist interest group of the British Society of Paediatric Radiology (BSPR) is running a workshop at its annual meeting (Leeds 2019) with a faculty composed of both the legal and medical professions, and input from a family court judge. The purpose of this workshop is to highlight the paucity of medical experts and attempt to demystify the process as a way to encourage more colleagues to become involved. The same specialist interest group of BSPR has published a consensus paper outlining its views as to how the situation may be improved. Although this focuses on the perspective of the radiologist we believe there are many parallels with other disciplines and complementary solutions. (*Oates A, et al. 2019*)

Recommendation 3

5. There should be improved collaborative working between Royal Colleges to ensure that issues pertaining to expert witnesses can be discussed collaboratively. Royal Colleges could consider appointing a lead clinician/Officer for expert witnesses, to appropriately support members or an officer for safeguarding children issues which would include relating to court processes.

Commissioners and NHS Trusts

Recommendation 4

6. RCPCH, RCR and other Medical Royal Colleges to engage with commissioners and/or Trusts/Health Boards to enable their members to have conversations with their employers and encourage them to support expert witnesses to participate in this work. RCPCH to outline the value of expert witness work, in particular quality improvement and training aspects. RCPCH and RCR to write and share a letter with Medical Directors/Chief Executive of Trusts with a summary of report findings and recommendations to encourage staff members to provide expert witness work.

Recommendation 5

7. RCPCH and others to engage with NHS England and Clinical Commissioning Groups (CCGs) to promote expert witness work and consider the review of commissioning arrangements in England. NHS England should consider providing centralised payments for work through Trusts, who could be commissioned to undertake expert witness work. As the expert witness typically receives remuneration independently from the NHS Trusts by which they are employed, we feel that this area of work is often “forgotten” by commissioners and employers where in reality it is of such fundamental importance it should be at the centre of the way paediatric services are provided. Commissioning arrangements in Wales should also be considered. In the longer term

this may result in a nationally-commissioned service (funded centrally) analogous to the Childhood Epilepsy Surgery Service (CESS) which seeks to standardise and improve quality of input into court processes across England and Wales.

Payment

Recommendation 6

8. The LAA's guidance for expert witnesses should make it easier to obtain prior authority to instruct an expert. The process for prior authority should be reviewed as to whether it is needed in some circumstances and the process should be simplified. One prior authority approval made by one nominated party's solicitor should apply where an expert is jointly instructed, and the expert instructed should only have to issue one invoice to the lead solicitor or, better still, directly to the Legal Aid Agency to obtain payment and avoid the requirement for submitting multiple invoices to all the respective parties (sometime 6 or more). It should be possible for one prior authority application to be made on one occasion in relation to the instruction of multiple experts.
9. This may assist in expediting the process and also assist the LAA in ensuring value for money and that certain experts are not charging for excessive number of hours.

Recommendation 7

10. Issues around the numbers of hours allowed by the LAA for experts should be addressed, including for some larger assessments and so to appropriately reflect the amount of time producing the report and for dealing with any questions, experts' meetings or other work further to the filing of experts' reports.

Recommendation 8

11. Some of the lower legal aid payments for experts, particularly the removal of the London/non-London differentiation, should be reviewed.

The Court Process

Recommendation 9

12. Judges should be prepared to remove cases which require a number of expert witnesses from the 26 week track at an early stage, and to allow legal representatives to have time to master the paperwork in advance of the expert instruction.

Recommendation 10

13. All legal professionals including Judiciary to adhere to the contents of Part 25 and PD 25 with particular reference to the following:
 - (i) Instruction of experts matter for CMH (i.e. early within the proceedings).
 - (ii) Questions are part and parcel of the application and not to be agreed out of court after the hearing.

- (iii) The order should identify the issues to which the evidence relates as well as set out the questions to be asked which should be:
 - a. clear, focused and direct,
 - b. kept to a manageable number
 - c. avoid irrelevant detail;
- (iv) The letter of instruction requires judicial approval.
- (v) For there to be proper co-ordination between the court and the expert when drawing up the case management timetable – the needs of the court being balanced with the expert who has a primary obligation/professional duties elsewhere.
- (vi) To provide a bespoke expert’s bundle culled from the main bundle, including the full index and updating that bundle as further relevant material is provided. That should be an e-bundle in an accessible format which can then stand as the witness bundle for the expert at trial. Local Authorities to create e-bundles from which the experts Core Bundle can be created.
- (vii) Strict adherence to the 10 day rule for the purpose of unilateral questions seeking clarification of any aspect raised in the report; such questions to be channelled on one occasion through the single point of communication.
- (viii) Experts’ meetings:
 - a. 5 business days for the preparation and circulation of an agenda which includes questions to be raised which should avoid repetition of previously asked questions and which seek to pre-attempt likely cross-examination
 - b. 2 days for the distribution of that agenda to the non-legal participants
 - c. Exceptional circumstances for under two days and no allowance made for on the day or in the meeting questions
- (ix) Enabling a mutually convenient date and time to be arranged for the expert to give evidence well in advance of the final hearing, such dates to be guaranteed to avoid disrupting clinical commitments.
- (x) Specific consideration of the use of appropriate technology (telephone, video link, Skype) to enable evidence to be given without the requirement to travel to court.
- (xi) Requirement to file documents affecting the expert to be served on the expert within 2 days of receipt of that document

Recommendation 11

- 14. Legal Aid public funding should be available without prior authority being required to fund a service provider to rationalise and order medical records chronologically prior to the medical records being dispatched to an expert witness.

Treatment of experts

Recommendation 12

- 15. When an expert gets into the witness box, depending upon his or her particular level of expertise, the judge should be encouraged to explain the purpose of any cross

examination which will follow; in other words that it is to test their evidence as part of a process that will enable the judge to come to the best possible decision for the child.

Recommendation 13

16. Whilst judges can and must criticise experts where necessary, where they intend to go beyond giving reasons as to why any of their evidence is not accepted they must always question the purpose of doing so and the effect that such will have upon the expert in question and experts more generally.

Recommendation 14

17. When a judge proposes giving a judgment which calls into question the professionalism or expertise of an expert, that expert should be sent a copy of the transcript of the draft judgment and given the opportunity to respond, whether in writing or by appearing before the court before publication.

Recommendation 15

18. A direction should be made, at the conclusion of any hearing where an expert has been instructed and has provided evidence to the court whether by way of written report or oral evidence, directing the lead solicitor for the instruction to send a copy of the judgment to the expert.

Training

Recommendation 16

19. A vehicle for Inter-disciplinary training, mentoring and feedback should be developed to deliver

- Training programmes for legal and medical professionals on issues relating to expert witnesses
- To develop and implement mentoring schemes for medical experts whether they are within the medical profession or ideally with an element of inter-disciplinary mentoring
- A vehicle for feedback from the legal profession, in particular the Judiciary to experts ranging from simple notification of the outcome of a case through to constructive criticism to aid professional development as well as informal ‘complaints’ as an intermediate level response to any identified failings in the provision of expert evidence which do not warrant referral to the GMC.
- There should be a proper budget for such training

Recommendation 17

20. Barristers, solicitors and judges should be approached to assist with witness training. Judges should be permitted to do this in working time and barristers and solicitors should be paid. The aim of this should not only be to assist the experts to give their best

evidence, but also to dispel some of the anxieties many have about cross examination and the attitudes of the courts.

Recommendation 18

21. The Family Justice Council should be invited to extend the mini-pupillage scheme for expert witnesses to a national level and to include senior registrars and junior consultants to familiarize themselves with courts in order to fully understand their role as treating clinicians and as future experts, and for experienced consultants who are contemplating commencing expert witness work. To consider whether to recommend that such should be required training for all paediatricians with key safeguarding roles (Level 4 and 5) as per Safeguarding children and young people: Roles and competencies for paediatricians and those experts who work with children.

Recommendation 19

22. Specialist organisations such as the Family Law Bar Association, The Association of Lawyers for Children and Resolution should review their advocacy training and how it covers the issue of effective cross examination of experts. Training should be done by practitioners, judges and experts themselves.

Recommendation 20

23. An expert witness handbook or information pack for experts and lawyers should be commissioned.

Supporting and Sustaining Change

Recommendation 21

24. The FJC establishes a Sub-Committee with representation from the health and legal sides to oversee the implementation, monitoring, administration of the recommendations over the short, medium and longer term. The Committee would report to the Family Justice Council and to the Family Justice Board.

Recommendation 22

25. The working group recommends the establishment of regional 'experts in the family justice system' committees under the Chair of the Family Division Liaison Judge with deputies from a lead lawyer and medical profession in the region. The committee would be comprised of legal and medical/healthcare professionals in order to address the shortage of medical experts and to implement at a regional level the recommendations for training and interdisciplinary collaboration including mentoring and feedback forums.

APPENDICES

Appendix 1

Consultation questions

Medical colleges

1. Is it viable for each of the Royal Colleges who are significant stakeholders in terms of their members providing expert evidence to the family courts, providing an online resource checklist to support their members to understand family court processes and their duties as professional and potential expert witnesses? To what extent is this already done?
2. What mechanism would best ensure that the Royal Colleges were able to collaborate to share such resources and to avoid reinventing the wheel?
3. How best can Royal Colleges increase awareness of existing training for healthcare professionals involved in expert witness work. Are special interest groups or subcommittees a viable way of the Royal Colleges most effectively disseminating such information.

Commissioners and NHS Trusts/Health Boards

4. Do commissioners and NHS trusts agree that expert witness work is of value to the individual clinicians and to their employing organisations? How best can commissioners and NHS Trusts/Health Boards support their employees who wish to carry out this work?
5. What might be feasible in terms of changes to commissioning arrangements which would incorporate expert witness work within relevant contracts? Should this be done on an individual commissioning body/service planning basis or might a nationally commissioned service be a realistic goal?

Payment and legal aid

6. How best can the mechanism for obtaining funding be simplified so as to reduce the administrative burden on solicitors and experts?
7. Are there changes which need to be made to the number of hours permitted in respect of particular sorts of reports? How should cases be identified which fall within or outside standard allowances?
8. What is the differential in hourly rates paid to medical experts as between privately or insurance funded work and legally aided work. Is it accepted that there is a disparity which needs addressing? If so in what areas is the disparity most acute? What mechanism is needed to establish the appropriate rate for different categories of experts.

Court processes

9. Should cases more routinely be removed from the 26 week track as a consequence of the need to ensure the court has the correct expert evidence before it? How best can compliance with the requirements of FPR 25 be achieved? Should a checklist accompany each application which is completed prior to orders being made? Should a standard form order which incorporates all relevant elements be a part of every order providing for expert evidence.
10. How best can the necessary documents for an expert be identified? Would the use of a medical records indexing agency be likely to lead to time and costs savings in respect of the expert such as to make the use of such a service a reasonable use of public funds?
11. Is a single point of communication (probably the lead solicitor) a viable means of ensuring that the expert is provided with all documentation and questions in an administratively simple way?
12. Is it feasible to fix a guaranteed date for the experts to give evidence within a trial template? What would be needed to ensure this was possible.?

Treatment of experts

13. Is it appropriate for a judge to explain to an expert the issue in relation to their evidence which has required their participation in the hearing and the purpose of cross examination?
14. Is it appropriate to seek to limit the nature of criticism of an expert save where they have plainly failed to comply with their duties to the court or their own professional ethical duties? Is some form of intermediate level of informal complaint mechanism appropriate in this context?
15. Is it appropriate to give an expert a right to comment on a judgment which proposes to criticise them in respect of a failure to abide by their duties to the court or their professional duties? If so how can this be achieved in a realistic timeframe? If there are issues as to a failure to abide by their duties should this be raised with the expert when they give their evidence rather than at the judgment stage?
16. Should any expert receive a copy of the final judgment? Is a précis of some form more appropriate? If so who would draft this?

Training

17. Should interdisciplinary training, mentoring and feedback form part of the recommendations? What ethical problems may arise and need to be addressed both in relation to mentoring and feedback?
18. What source of funds would support formal interdisciplinary training? Could the Royal colleges and the judicial College collaborate to training programmes? Should training incorporate formal training through the Royal colleges and the judicial College alongside less formal training provided by volunteers through regional committees? What should be the content of ongoing training?

19. How best can mini pupillages/mini marshals for medical professionals to spend time with judges/barristers/solicitors be utilised? Should these mini pupillages also include experiences within the criminal justice system? What administration would be necessary to implement such a scheme on a national/regional level? Who is best placed to deliver this? Can the family Justice Council in collaboration with family division liaison judge's deliver this?
20. What training currently exists within specialist organisations such as the ALC, resolution and the family law bar Association in relation to training lawyers in relation to handling expert witnesses? To what extent is there existing interdisciplinary training run by these organisations? Are there any models which could be used for national regional training?
21. How could an expert witness handbook or information pack for experts and legal professionals be commissioned?

Supporting and Sustaining Change

22. Is a sub-committee of the Family Justice Council the most appropriate and effective vehicle for carrying forward in the short medium and long-term the recommendations of the working group? How should the interplay between the family Justice Council and the family justice board be addressed? What administrative resources would be required and would be available to support the work of the subcommittee which in particular might play a role in managing the mini pupillage scheme (as it currently does)? What should be the functions of the subcommittee?
23. Are regional "experts in the family justice system" committees the most effective way of delivering training, mentoring and feedback opportunities? How can local family justice boards be incorporated into the process of ongoing implementation of training, mentoring and feedback? What should the membership of such regional committees be? Is the circuit family division liaison judge the best person to chair such committees? How should such committees be administratively supported? What reporting back functions could they properly be expected to have in relation to the family Justice Council subcommittee?

Appendix 2

Medical Survey questions

1. What is your College?
2. What is your specialty?
3. What is your nation / region?
4. Do you currently (within the last year) provide expert witness work to the Family Court?

5. If no, have you previously provided expert witness work?
6. Do you understand the difference between the duty to the court as an expert witness and being a treating clinician?
7. Have you ever provided a written report in court as an expert?
8. Have you ever provided a written report in court as a treating clinician?
9. Please rate the below statements (1 being 'not supportive' and 5 being 'very supportive')
 - a. Your Trust / Health Board is supportive of its employees (including yourself) taking part in expert witness work
 - b. Your College is supportive of its members taking part in expert witness work.
10. Please rate the below statement (1 being 'not attractive' and 5 being 'very attractive'): Expert witness work is financially attractive
11. Have you ever had any expert witness training?
12. Would you be interested in receiving training to support expert witness work?
13. If yes, what sort of training? Please comment below.
14. Even if you are not currently undertaking expert witness work, what (if any) do you believe are the barriers to doing expert work? Please select your top 5 choices only
 - a. Criticism (unfair) in the media
 - b. Criticism (unfair) from the Judiciary
 - c. Lack of adequate remuneration for the work at statutory rates
 - d. Antiquated payment/invoice system
 - e. Delay in payment
 - f. Perceived inflexibility in terms of timetabling by the court
 - g. Vast material to read through
 - h. Obtaining CPD recognition for work
 - i. Lack of College support to do the work
 - j. Lack of training
 - k. Lack of protected time/support/job planning from individual Trusts/Health Boards
 - l. Lack of support from peers
 - m. Not interested

- n. Geographical distance
 - o. Technological barriers giving video evidence
 - p. Financial (including tax and/or pension) implications in doing this work
 - q. Use of family justice expert reports within the criminal justice system
 - r. There are no barriers
 - s. Other (please specify)
15. Do you have any suggestions of solutions to overcome any of the barriers you have selected? Please comment below.
16. Would you be willing to get involved in helping provide a solution? If yes, please provide your email address below and we will update you on progress of the working group and relevant future opportunities relating to expert witness work. This information will only be used for the purposes stated.

Appendix 3

Legal Survey Questions

1. Are you a Barrister/Solicitor/Judge/other?
2. Which area of the country do you practice in?
3. Have you experienced a shortage of medical expert witnesses (including mental health experts such as psychologists and Child and adolescent psychiatrists) to assist the court in resolving public and private law Family cases concerning children?
4. If yes, in which medical disciplines have you experienced a shortage and where?
5. Please provide examples of what impact this has had on individual cases?
6. In your experience to what extent, if at all, is any shortage caused or exacerbated by?
7. If you are able to give any specific examples in relation to these (albeit if appropriate anonymising the identity of the expert) that would assist.
8. Are you aware of medical specialists who are unwilling to become expert witnesses or provide expert opinion evidence (as opposed to purely factual material such as medical records or material)?
9. Are you aware of medical specialists who will provide a report as a treating clinician but are not willing to participate in experts' meetings or to give oral evidence to the court?
10. 10. Have you noticed any decline in the quality of the medical experts who are proposed as medical expert witnesses or a decline in the quality of the medical expert reports provided and if so in which areas of expertise?
11. If yes, identify the areas of expertise from the following
12. Are there any observations you wish to make about expert witnesses, and, if you do consider that there is a shortage of experts willing to assist the courts, what might be done to encourage them to do so?

13. Are you aware of any initiatives which have been taken to address the issue and are you able to provide any information about such initiatives and on the impact of such initiative?
14. Any other information or observations?

Appendix 4

Answer Choices	Responses	
Criticism (unfair) in the media	35.26%	134
Criticism (unfair) from the Judiciary	23.95%	91
Lack of adequate remuneration for the work at statutory rates	57.11%	217
Antiquated payment / invoice system	26.58%	101
Delay in payment	37.63%	143
Perceived inflexibility in terms of timetabling by the court	38.42%	146
Vast material to read through	37.89%	144
Obtaining CPD recognition for work	9.47%	36
Lack of College support to do the work	5.53%	21
Lack of training	19.21%	73
Lack of protected time / support / job planning from individual Trusts / Health Boards	35.00%	133
Lack of support from peers	4.21%	16
Not interested	4.74%	18
Geographical distance	6.32%	24
Technological barriers giving video evidence	6.05%	23
Financial (including tax and / or pension) implications in doing this work	23.42%	89
Use of family justice system expert reports within the criminal justice system	9.47%	36
There are no barriers	1.32%	5
Other (please specify)	23.95%	91
	Answered	380
	Skipped	32

