Bearing Good Witness

Response by the Family Justice Council

General Comments

1. The Family Justice Council welcomes the report as a radical attempt to tackle the long-standing supply and quality issues associated with medical expert witnesses in family court proceedings.

2. The Council endorses the key principle underpinning the Chief Medical Officer's Report that "providing expert medical evidence in Public Law Children Act proceedings should be delivered as a public service, fully consistent with the duty on the NHS to safeguard children."

3. In the Council's view, this statement of intent has the potential to change the culture and the behaviour within NHS organisations and of health and other relevant professionals. Whilst 'Working Together' and the National Skills Framework place duties on health services, to safeguard children and to work with other agencies, the point at which the legal system becomes involved has caused difficulties for health professionals and organisations. In describing expert evidence as a public service consistent with the duties of the NHS, this acknowledges the true interdisciplinary nature of the proceedings. The expert's duty remains to the court and not to the parties or employing NHS organisation.

4. Accountability and governance are at the core of this cultural shift. Placing this work firmly within the NHS means that the systems of training, accountability and governance can all be applied in a transparent manner, which, over time, should deliver improvements in the timeliness and quality of expert evidence. The teams will provide peer review which together with some form of accreditation for expert witnesses and the clinical governance that will come from embedding this work in the NHS should all have a positive impact on quality.

5. A general point of considerable importance concerns the clarification of the terms 'witness of fact' and 'expert witness' and the consequences of this particularity for professional training. This is an important distinction and clarification is welcome. The report describes the treating doctor, as a witness of fact, and continues to say:

> "it is sometimes assumed that a witness of fact should not provide an opinion as to causation of the condition or injury. This is not so, and is part of the role of a treating clinician. A doctor who is required to be a witness of fact may have just as much expertise and experience as a medical expert witness. Magistrates and Judges, by making more use of the evidence of witness of fact, which can also include Social Workers involved with the family, can reduce the demand for independent medical witnesses."

"This report is about independent medical expert witnesses whereby the expertise derives from doctors' qualifications and experience rather than their eminence."

6. In the Council's view, the treating physician can be just as much of an expert as an expert witness giving evidence in court proceedings. The only difference is that the treating physician, or expert of first referral, has developed a patient/doctor relationship whilst an expert instructed later will not have the same time and opportunity to develop a patient/ doctor relationship. In this regard, the Council must respectfully disagree with some of the conclusions Baroness Kennedy's Intercollegiate Working Group reached on expert witnesses in 2004. In its report on Sudden Unexpected Deaths in Infancy, the Working Group made the following observations:

> "*It is our view that paediatricians involved in the acute management of patients should not be expected to give expert testimony in cases involving those patients. It is a sine qua non that doctors treating patients must develop partnerships with them and with the immediate family to ensure the best medical outcome. This will inevitably result in a degree of intimacy and therefore subjectivity when evaluating the case as a whole. This is the opposite of what is required of the expert witness, who should be objective, impartial, detached*".

7. Baroness Kennedy is, of course, a distinguished criminal lawyer and the Council does not take issue with the relevance of the findings of the Working Group to criminal proceedings. However, in the view of the Council it would be perfectly proper for paediatricians involved in the acute management of patients to provide expert evidence in *family* court proceedings. The Council does, however, recognise that in a proportion of cases an independent assessment will necessary or desirable.

8. Until more clinicians are competent and confident witnesses then there will continue to be supply problems with expert witnesses willing and able to give evidence in family proceedings. This is the pool from which the independent expert witnesses will develop. The emphasis on training and supervision is of key importance to the success of the CMO's proposals.

9. We wish to emphasise the importance of looking at the provision of expert witnesses in the context of the relationship between local authorities and health authorities in providing services in cases which concern child protection and family breakdown generally. The Council has explored this relationship in its response to the Review of the Child Care Proceedings System in England and Wales:

> *"It is our view that local medical and psychiatric services are not sufficiently well integrated into the child protection process in many areas to provide either support or assessment services within the necessary timetable for care proceedings." (para 3,*

page 2, October 2006, full response available at www.family-justice-council.org.uk/docs/060922)

10. The CMO's report focuses on expert evidence in public law proceedings; the need for expert evidence in some particularly difficult private law cases, should in our view be considered at the same time. There can be a need for psychological evidence and for an assessment of, for example, allegations of sexual abuse in private law cases on residence and contact where the needs of children cannot be met without an expert analysis of the factual history and the future needs of the child. As in public law proceedings, the need for expert witnesses runs side by side with the need for services to support families in this kind of case.

The CMO's Proposals

11. **Proposal 1** – See general comments above. This is fundamental to the report and, together with the question of resources and effective development and management of the changes, represents the key challenge. The Council is aware that many clinicians have expressed scepticism as to the capacity of the NHS organisations to deliver the changes proposed within any reasonable timetable and that some clinicians have concerns as to the NHS organisations' ability to select the most appropriate specialists for the teams. The Council is also aware of the concerns of some specialists that the changes may initially exacerbate supply problems. This is because some consultants in shortage specialisms may cease to provide expert reports if they are no longer to be remunerated specifically for this work.

12. In the long term, however, the Council is of the view that the proposals set out in the CMO's report offer a sustainable path to increasing the supply and quality of expert evidence. The Council sees no reason why a 'mixed economy' of NHS teams and privately commissioned expert's reports should not exist side by side. In the Council's view, the changes proposed in the CMO's report are likely to take in the region of 5 years to be rolled out across the country. At the end of this period, the Council would expect to see the bulk of expert reports commissioned from the NHS teams but there will always remain some scope for independent work for some specialists outside the NHS. The courts will need an alternative resource where:

a) the local team lacks a specialist in a particular field - consultant paediatric neuro–radiologists, consultant paediatric pathologists and consultant paediatric haematologists are all, for example, not readily available outside the major cities.

b) the local team cannot provide reports to an acceptable timescale.

13. **Proposals 2 and 3** – The Council endorses the team approach and agrees that it will not be possible to be overly prescriptive as to their composition. A team offering an opinion on a child with a non accidental head injury will, of necessity, be different from a team considering parenting, adult

mental health and capacity to change. The assessment methods will be different and might include paper reviews, single interviews, community or residential assessments. This needs to fit with the development of managed clinical networks for Paediatrics and Child and Adolescent Mental Health services.

14. It is proposed that contracts, or service level agreements, are to be held by named organisations or multi-disciplinary teams and not individual named clinicians. This will depend upon the type of team as described above.

15. There are examples where existing managed clinical networks work well. These tend to be concerned with clinical areas of low volume incidence with high costs and often highly technical and specialised requirements. The development of multi disciplinary specialist expert teams would fit this description. However, although the Council supports the team approach, this is on the clear understanding that if a specific area of a report is to be challenged in cross-examination at trial, then the specialist responsible for the relevant part of the report must give evidence – not an expert in a different specialism on the same team.

16. We endorse the view of the CMO that in some cases it will be necessary for experts outside the team framework to be instructed both, on occasion, for particular specialist knowledge and, on occasion, because there is a need for an analysis from an expert outside the local team. Although in the majority of cases the team approach will be appropriate, working in a team can lead to consensus building and in some cases each element of the analysis needs to be entirely independent so that any contradictions in the evidence can be fully explored.

17. The importance of leadership, mentoring, peer review and supervision must all be emphasised; as must a range of safeguards and, importantly, formal clinical governance arrangements. With whom such arrangements need to be made needs further debate. Who should have the task of quality assuring the teams and their reports? There will be an internal monitoring system within the teams but there should also be some external source of monitoring.

18. **Proposals 4 and 5** – The mapping of the existing geographical distribution of the specialist skills required for the teams will be a vitally important task. The starting point should be to identify the tasks required and then to consider the skills and competencies from which the team can be built up. The mapping exercise should involve full consultation with the relevant professional/ clinical bodies (e.g. the Royal Colleges) in order to develop the competency frameworks and then the SHA to complete the geographical mapping.

19. **Proposals 6 and 7**. A form of cost and volume contract would seem to be most appropriate given that different teams will have a different range of costs. A paediatric team concerned with failure to thrive and acute injuries will have a different cost basis from a psychiatry/psychology team involved with

assessments concerning parenting, capacity to change with a possible residential component.

20. **Proposal 8** – There needs to be further and fuller exploration of what commissioning means with respect to experts. Will it include everything from public health epidemiological assessment of need, oversight of the service provided, quality assurance and monitoring of the process and the output? Or is it envisaged that the commissioners will act in the simpler role as purchasers of a product on behalf of other parties? In the Council's view, it should be the former as one of the key goals of the CMO's report is to promote improvements in the quality assurance and clinical governance of expert evidence.

21. The Council is unaware of any organisation which currently could fulfil all the tasks required of commissioning a new expert assessment and evidence service. The Council suggests that a new relationship could be established between the commissioning arm of the Primary Care Trusts (PCTs) and the Legal Services Commission. A key role of PCTs is to act as a commissioning organisation. PCTs have the public health skills and are now developing the full range of commissioning competencies. The LSC has knowledge, expertise and experience of the role of expert evidence in legal proceedings. The commissioning role could be split between the two organisations where the LSC has responsibility for accepting the task on behalf of all the parties (with all the necessary checks and balances on instructions, timing and finance) and the PCT managing the initial part of the system (needs assessment, work force planning etc) and the end of the system (quality assurance and clinical governance). The key challenge will be to avoid an arrangement that is overly bureaucratic, slow and expensive.

22. There is a need to distinguish the commissioning of the service generally and the commissioning of each report which, we believe, should remain, as it is now, in the hands of parties to the proceedings.

23. **Proposal 9** – This is a logical extension to the development of teams for expert witness work or, in some cases, it will be the initial step which leads on to the expert teams. There are already some teams which provide a coordinated team report early in the proceedings either in support of the local authority initially or at the causation hearing. These could be and, in many cases, will be the same team which can provide the independent expert reports. The organisation of the funding arrangements for these reports is simpler than that of experts. Many paediatricians, for example, already see this as part of their core NHS work. It is much less of a leap to develop further this part of the service than the expert witness service.

24. **Proposal 10** – The Council agrees with the CMO's view that there is scope for improving the instructions provided to medical expert witnesses and that the Law Society and the medical professional bodies should be asked to examine this issue. The Council has previously undertaken work in this area and has produced model 'questions in letters of instruction to child mental health professionals or paediatricians in Children Act 1989 proceedings'.

These questions have been fed into the review of the Public Law Protocol and, the Council understands, are likely to be included in a forthcoming practice direction.

25. **Proposal 11** – The Council supports this proposal and notes that several of the Royal Colleges are already including child protection training in their Continuing Professional Development.

26. **Proposal 12** – Under 'Modernising Medical Careers', competency based training is now part and parcel of training of a doctor. As described above, child protection training which will include court skills training is under development. Regular appraisal is mandatory. To include specific matters within the appraisal (for example child protection /court reports) would be an important and relatively straightforward step towards greater quality control. Therefore, for those doctors coming through the system now, there should be some assurance that there will be built in systems of appraisal and assessment. The question arises as to what to do about those doctors already qualified and practising. Here, formal appraisals should offer a significant, though not complete, degree of assurance.

27. There are a range of views as to whether accreditation with an organisation other than the relevant professional body (i.e. the Royal Colleges) is the best way forward. On balance, in the Council's view the focus should be on encouraging suitably qualified experts to come forward to do this work, rather than on erecting further barriers. The Council is not aware of any system of accreditation which would have excluded any of the experts whose evidence has given rise to public and GMC concern.

28. **Proposal 13** - The Council supports this proposal and notes that the GMC has published revised guidance on 'Acting as an Expert Witness' and that this is currently out to consultation until 26 March 2007.

29. **Proposal 14** - The Council agrees this proposal. The Council notes that many clinicians cite fear of vexatious complaints to the GMC as a disincentive to do expert work for the family courts. In the Council's view, the uncertainty and anxiety generated by vexatious complaints could be reduced by the family courts offering more timely assistance to the GMC, and the British Psychological Society, in terms of making available any judicial assessment of the expert's contribution and ensuring any relevant case papers are released as soon as possible after a complaint has been made. This would make it easier to determine quickly those complaints which were without any foundation.

30. **Proposal 15** – The Council endorses the check list and considers that this would help legal practitioners and the courts to establish and test the credentials of medical expert witnesses.

31. **Proposal 16** - The Council supports this proposal. A database identifying recent developments, areas of controversy, and needs for further

research could be useful to medical experts. The challenge would be to ensure that such a database was kept up to date.