Bearing Good Witness

Proposals for reforming the delivery of medical expert evidence in family law cases

A report by the Chief Medical Officer

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October 2006

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Preface

I was asked by Ministers to produce this report and recommendations on medical expert witnesses in family law cases in response to some very high-profile court cases that called into question the quality of medical expert witnesses in certain types of case. In developing my proposals, it has become clear to me that the problem is more one of supply than of quality. Nevertheless, the courts need to be confident both that an appropriate witness will be available when needed and that the evidence provided is of the highest quality, is based on high-quality research and represents the current state of knowledge about the issue in question. Therefore, my proposals address both quality and supply.

The proposals are driven by my conviction that it is the duty of medical professionals and health organisations to safeguard children. For the NHS, that duty is now set out in law in the Children Act 2004. Ensuring that the family courts have access to the best information when making decisions that will affect the lives of some of our most vulnerable children is closely linked to that duty. I therefore propose that we move away from the current system of solicitors paying fees to individuals to a new system whereby a public sector organisation, on a local or regional basis, reaches agreement with NHS bodies to provide expert advice, so enabling NHS bodies to help protect vulnerable children.

These are radical proposals which will require far-reaching changes to the way that medical expert evidence is provided to the family courts and in the relationship between family courts and the local NHS. Most importantly, they are changes that I believe will improve the way that decisions are taken about children whose future depends on state intervention.

I recognise that making these changes will not be straightforward and will take time. However, I believe that, without them, we will not be able to ensure a supply of competent medical expert witnesses to the courts in the future.

In developing my proposals, I was mindful that the challenge of developing a new resource for the family courts reflects the wider issues faced in NHS workforce development, where the aim is to meet service need by growing the workforce, modernising roles and regulation, improving competence through education and training whilst expanding the choice available to users. This applies as much to paediatrics and psychiatry as to other specialties. My proposals for delivering medical expert witnesses through a contract or service level agreement between a public sector organisation that may be best placed to commission the medical expert witness service, on a local or regional basis, and NHS organisations, will help to anchor the expert witness function in family law cases within both NHS trusts,

foundation trusts and primary care trusts, and workforce development more generally. The changes will, however, need to go beyond both sectors because my proposals are also about doing things differently. They will require the legal and medical professions – including judges, solicitors, barristers, magistrates, doctors and other members of the healthcare professions – to find new ways of working with each other to ensure that skilled medical expert witnesses are supported, encouraged and trained.

I also hope that my proposals will be supported by the majority of clinicians in the specialties needed in the family courts. Without their support and commitment to this work, the courts will not be able to meet their responsibilities to children. We owe it to children to make the changes which will secure the right outcomes for them and which will do so without delay.

As the proposals are far-reaching, they will be the subject of a consultation process – not only to test the proposals themselves but to seek to understand the challenges and risks to their implementation and obtain the views and advice of those who will be most affected by the changes.

Although the proposals are radical, in some areas of the country schemes similar to those that I am proposing, or including elements of them, are already in place and some areas will be better prepared than others to make the changes. For this reason, rather than piloting the proposals in a limited area, I recommend that – after taking into account the outcomes of any consultation process – the proposals should be implemented on a rolling basis as the NHS groups or teams come together locally or grow in capacity.

Finally, a number of individuals and organisations gave their time to help with this study and I would like to express particular gratitude to all of them.

Sir Liam Donaldson
Chief Medical Officer
October 2006

Executive summary

- This report reviews the use of medical expert witnesses within the family courts, and specifically in public law Children Act cases. It aims to identify the main problems with the current system and make proposals both to resolve them and to secure a sustainable supply of competent, quality-assured medical expert witnesses for care and supervision cases in the future.
- Public law Children Act proceedings consider the welfare of one or more children who may be at risk. The job of the court is to decide whether the child has suffered harm or is at risk and what arrangements should be made for his or her future placement and care.
- A medical expert witness is a qualified doctor who produces a report (based on assessment of the evidence and often of the child or other individuals involved) and may then appear in court to give evidence and be cross-examined.
- Many doctors who act as witnesses in court do so as 'witnesses of fact', in other words they are the doctor who has treated the child. Others are external to the care of the child or the family concerned. The specialties of paediatrics, child psychiatry, adult psychiatry and psychology are those most heavily involved, though highly specialised disciplines such as paediatric radiology and pathology are vital sources of expert evidence in family law proceedings. Other health and social work professionals may also be involved.
- A recent review of cases of children who were the subject of care orders showed that only in a very small number of cases (26 out of 28,687) was the court's decision based on a serious disagreement between medical experts about the cause of harm.
- The main stakeholders involved in care and supervision cases generally valued the role played by medical expert witnesses within the system and the quality of those they had dealt with, but solicitors regularly encountered serious difficulties with:
  - obtaining a suitable medical expert when one was required;
  - knowing what skills and competencies might be necessary for a particular case and then finding the right doctor who has them;
  - securing a report on time from medical experts with a very heavy caseload.

- There are serious difficulties in maintaining an adequate supply of medical expert witnesses because:
  - the system is not well organised and is dependent on multiple small agreements between individual doctors and solicitors;
  - there is no real succession planning so, as experienced doctors retire, there are few younger doctors stepping in to replace them;
  - most medical expert witness work is concentrated in a relatively small number of hands;
  - highly specialised medical input is sometimes vital to the courts (eg paediatric radiology) and there are few specialists nationally in such disciplines;
  - too few doctors are encouraged or motivated to be regular expert witnesses.
- Doctors as individuals are deterred from being expert witnesses because:
  - there are few good comprehensive training programmes;
  - some find the courts and legal processes intimidating and stressful;
  - many find the court processes bureaucratic, slow and time consuming;
  - some fear referral to the General Medical Council by vexatious parties in a case.
- The commonest reasons for a doctor never having acted as an expert witness are not being asked or not feeling qualified to do so.
- The main problem with the expert witness system is securing and sustaining a suitable supply of individuals willing to, and capable of, doing the work; however, there is no comprehensive quality assurance system for the work of medical expert witnesses or for their professional development.
- Sixteen proposals set out below seek to provide a well-organised system to ensure a sustainable supply of medical expert witnesses in the future and provide mechanisms to quality assure and continuously improve their work.

Summary of proposals

i. Providing medical expert 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.

ii. NHS Trusts, Foundation Trusts and Primary Care Trusts (referred to in this report as NHS organisations) with substantial paediatric, child psychology and psychiatry and/or adult psychology and psychiatry services, should provide medical expertise to the Family Courts through the formation of groups or teams of clinicians within the same specialty or on a multi-disciplinary basis. Teams may include other specialists from within the trust, for example radiologists or ophthalmologists who frequently act as witnesses in family law cases, and clinicians who have retired within the last two years from active clinical practice. In time, such groups or teams in adjacent NHS organisations may form managed local networks to enhance the viability of their services, specialisation and spread of expertise, and to share their resources and training more effectively.

iii. The main contract or service level agreement for providing medical expert evidence to the family courts within a particular area should, in future, be held by one or more NHS organisations and delivered by specialty or multi-disciplinary teams, rather than by individual named clinicians. This would not preclude parties to a case asking for an expert from outside the area or for one working as a private individual.

iv. NHS human resources teams in participating trusts should include an assessment of the workforce implications for their trust in their development plan and, in particular, should include an assessment of their long-term staffing needs and a plan to build up the workforce.

v. Regional Directors of Public Health should co-ordinate implementation of the proposals that relate to the NHS. The Department for Constitutional Affairs, the Department for Education and Skills and the Department of Health, working with the Family Justice Council, could oversee and report progress on all aspects of implementation.

vi. The costs for the NHS in taking on this additional workload and in training and development to deliver a quality supply of medical witness expertise in the future should be fully met (currently the cost of experts is shared by the Legal Services Commission and local authorities).

vii. Funding of medical expert witness work from the NHS should be on the basis of an agreement on the service to be provided, its cost and volume, in line with most NHS activity, to ensure proper workload and workforce planning.

viii. The views of key stakeholders should be sought on which public sector organisation is best placed to commission the medical expert witness service from the NHS.

ix. When the commissioning organisation has been determined, consideration should be given to whether there is scope to rationalise the funding system for expert witnesses used in public law Children Act proceedings.

x. The Law Society, in consultation with the Academy of Medical Royal Colleges and the General Medical Council, should consider how the quality of instructions to medical experts might be improved and should disseminate information to their members.

xi. The knowledge and skills needed in all court settings should be taught as part of basic and continuing medical education. Relevant educational and standard-setting bodies should develop a competence-based syllabus for court skills. Within this development, priority should be given to medical expert work in child protection cases.

xii. Under the *Joint Memorandum between the Academy of Medical Royal Colleges and the Department of Health*, collaboration should be extended by the Academy to other relevant professional bodies – for example, the British Psychology Society and the Council for the Registration of Forensic Practitioners – to develop accreditation for teams of medical expert witnesses based on ISO 9000.

xiii. The General Medical Council should review its supplementary guidance, *Giving expert advice*, to widen its scope and bring it up to date in relation to recent developments and issues in this area.

xiv. In the light of the consultation on *Good doctors, safer patients*, the Family Justice Council and relevant government departments should work with the General Medical Council (GMC) to investigate all possible ways of dealing with complaints to the GMC about the expert evidence given by a doctor, so as to ensure that routes of appeal through the courts are used when they are appropriate.

xv. The checklist suggested at paragraph 5.19 should be used by lawyers, magistrates and judges to establish the credentials of prospective medical expert witnesses.

xvi. A National Knowledge Service to support the medical expert witness programme should be established.

Chapter 1
Background

1.1 Over the last few years, there has been growing public unease about miscarriages of justice arising from the quality and validity of evidence given by medical expert witnesses in the courts. Convictions of mothers, for allegedly killing their children, have been subsequently overturned on appeal in the cases of Angela Cannings[1] and Sally Clark.[2] Another young mother, Trupti Patel, was found not guilty at trial.[2] The concerns have been triggered by a small number of cases in the criminal justice system and, in particular, those involving paediatricians. Some of the issues raised are nonetheless relevant to the whole spectrum of medical evidence, whether in criminal cases or public law Children Act proceedings.

1.2 As a result of these cases, the Royal College of Paediatrics and Child Health has expressed concern about the reluctance of paediatricians to give evidence as expert witnesses or to remain involved in child protection work.[3] The problem has been exacerbated by fear of litigation, controversy surrounding cases of fabricated or induced illness by carers (previously known as Munchausen's syndrome by proxy),[4] the introduction of (now discredited) diagnoses of 'temporary brittle bone disease',[5] and the self-explanatory term 'shaken baby syndrome', where diagnosis is as difficult as discovery of causation.[6]

1.3 Immediate action was taken to address potential miscarriages of justice in cases that had been heard in the criminal courts and in which medical evidence had played a key part in the judgment. It now appears that where there has been a sudden and unexplained infant death in the family, with a dispute between medical experts as to whether the infant has been unlawfully killed, and where there is no extraneous evidence of physical harm, convictions for those deaths are likely to be unsafe.[1] The Attorney General immediately reviewed all cases of cot deaths, including shaken baby syndrome, of parents and carers convicted of killing an infant under the age of two in the last ten years.[7] The review identified three cases where convictions relied on evidence similar to the Cannings case and a further 25 in which there was sufficient concern to warrant further consideration. All the cases were referred to the defendants' legal advisers. In February 2005, the Criminal Cases Review Commission referred the convictions of Donna Anthony[8] for the murder of her two children to the Court of Appeal, following the Court of Appeal's judgment in the case of Angela Cannings. The appeal was allowed in April 2005 on the grounds that the expert evidence had been misleading.

1.4 There had been similar concerns about how the judgment in R v Cannings might impact on care and supervision cases where there had been substantial disagreement between medical experts.[9] The Minister for Children issued guidance[10] to local authorities in February 2004 to review the cases of children who were the subject of current care proceedings or where local authorities were exercising responsibility for children who were currently the subject of care and related orders. Results from the initial survey[11] covered all cases of children undergoing current care proceedings; 130 out of the total 150 local authorities in England reported. The number of cases in which disputed expert medical evidence featured or was anticipated to feature was small, arising in only 47 out of the 5,175 cases. In all, 127 local authorities responded to the second stage review about children with care orders or freeing orders. Again, the number where the court's decision on significant harm depended on disputed medical evidence about cause was very small: 26 out of 28,687.

1.5 Alongside this, the Family Justice Council had been receiving reports that there was a severe shortage of clinicians prepared to give evidence in the family courts. Lawyers were concerned that most of those acting as expert witnesses were so busy that they could not complete cases within reasonable timescales. A number of highly respected clinicians who were very experienced medical expert witnesses had retired and no one seemed willing to replace them. I met with the President of the Family Division and leaders of the medical bodies to discuss this problem and listen to a range of views on causes of the supply problem.

1.6 It was in the context of these developments that I was asked by Ministers in June 2004 to advise on how best to ensure the quality and supply of medical expert witnesses in care and supervision cases.[11] Action was needed to restore public and professional confidence in the legal process and in the role played by medical expert witnesses.

1.7 During the course of my review, two appeals have taken place – the General Medical Council appeal against the High Court decision on Meadow v GMC,[12] on which judgment is awaited, and the case of JD(FC) v East Berkshire Community Health NHS Trust and Others (judgment 21 April 2005),[13] which is now before the European Court of Human Rights. In the latter case, a strong judgment from the House of Lords found that, in raising suspicions about child abuse, no duty of care was owed to the parents of the child. This case did not concern the role of a doctor acting as an expert witness in a child abuse case, but the court noted in its judgment that in the event the doctor would have an immunity from claims for negligence.

The terms of reference

1.8 The full terms of reference for my study, which was announced in Parliament, were:

a) to consider the role of expert medical witnesses in relation to family law cases, including:

(i) examining the experts' participation through the process and the competencies needed;

(ii) examining evidence of the best practice for expert witnesses;

b) to identify a template and portfolio of medical skills by which a practitioner may be regarded as 'competent' to offer evidence;

c) to advise on a sustainable supply of competent, quality-assured expert medical witnesses;

d) to report and make recommendations to Government Ministers in early 2005.

Gathering the evidence

1.9 I have drawn on the following sources of expert opinion, research and views to inform my consideration and compilation of this report:

- meetings with groups in the legal and health professions and, more widely, discussion with individuals from a wide range of organisations (see Annex A);
- reviews of documents on medical expert witnesses;
- correspondence from individuals and interested parties;
- a commissioned survey of clinicians in key specialties.

Other relevant initiatives

1.10 My report takes account of a number of other developments to improve the system of justice, some of which bear on aspects of the medical expert witness system. A number of reports have been published which collectively signal a major change in the way that family courts do their business and the experience of all those using them. These include:

- the Report of a Working Group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health.[14] This made a number of recommendations concerning the accreditation and training of medical expert witnesses in criminal cases;
- the House of Commons Science and Technology Committee report: *Forensic Science on Trial.*[15] Part of the inquiry was into the provision of effective forensic

science services to the criminal justice system; the report also examined the use of expert witnesses in forensic evidence in the courts, and some of its recommendations can be applied equally to improving the situation in the family justice system;

- the Legal Services Commission's consultation paper on raising the standard of forensic expert services through the use of accredited, quality-assured experts and guideline fee structures, *The Use of Experts – Quality, price and procedures in publicly funded cases.*[16] The final report is expected to take account of Lord Carter's review *Legal Aid: A market-based approach to reform*,[17] which sets out a programme of reforms to achieve a market-based system that will change the way the Government buys legal advice on behalf of the public. The Government's response to the Carter report is in the form of a formal joint consultation paper, *Legal Aid: a sustainable future*;[18]
- the *Review of the Child Care Proceedings System in England and Wales*[19] by the Departments for Constitutional Affairs and Education and Skills, which examines the extent to which resources in childcare proceedings are used in the most proportionate, efficient, effective and timely way, to deliver the best outcome possible for children and families, in a manner that is consistent with the underlying principles of the Children Act 1989. The review looks at the role played by experts in the family justice system and how they inter-relate with other professionals;
- *Confidence and confidentiality: Improving transparency and privacy in family courts*,[20] which makes proposals for improving openness in family proceedings while protecting the privacy of the personal lives of those involved in proceedings – especially children.

1.11 Several organisations are taking action to improve parts of the family justice system. I welcome the impact that some of these initiatives will have for medical expert witnesses and the NHS, particularly:

- the establishment of the Civil Justice Council's committee of experts, which began work in February 2003 to examine and report on experts in the civil justice system.[21] This is considering the role of experts generally but also looking at accreditation, training, professional discipline and court control of experts and fees;
- the establishment of the Family Justice Council[22] Sub Group on Experts;
- initiatives by senior judiciary, including their review of the operation of the *Protocol for Judicial Case Management in Public Law Children Act Cases*, which includes a code of guidance for expert witnesses and advice on managing the use of experts;[23]

- the installation of video conferencing facilities in care centres which will be made available to medical expert witnesses so that they can more conveniently give evidence and spend less time away from clinical duties;
- the initiative by the Association of Directors of Social Services to improve the training of social workers in court skills, with the aim of equipping them for that role and reducing the need for additional expertise;
- schemes to train psychiatrists to be expert witnesses, particularly those being carried forward by the Royal College of Psychiatrists;
- initiatives by the Family Justice Council to set up mini-pupillages for doctors in training to introduce them to the work of the court;
- an initiative by the Academy of Medical Royal Colleges and General Medical Council on the training needed in court skills for medical expert witnesses at undergraduate and postgraduate levels;
- work by the General Medical Council designed to speed up the process for dealing with complaints against doctors who have acted as expert witnesses. However, this may be superseded by the recommendations in my recent review *Good doctors, safer patients*,[24] which is the subject of public consultation until 10 November 2006.

1.12 *Good doctors, safer patients* reviews current arrangements for assuring the quality and safety of doctors' practice, including the system of medical regulation. Subject to the outcomes of consultation, its recommendations will have a far-reaching impact on the future role of the General Medical Council and, therefore, on the context for proposals I have made about medical expert witnesses in chapter 5 of this report.

The vision

1.13 The majority of medical expert witnesses deliver their court work to a high standard. Commissioning and delivery arrangements must enable this to continue, but even the best system cannot guarantee that mistakes will never be made by doctors giving evidence in court or that miscarriages of justice will not arise as a result. Improvements to the system should, however, minimise the risks of these occurring in future by ensuring:

- a sustainable supply of quality-assured, competent medical expert witnesses who can apply their work knowledgeably and responsively in the context of court processes;
- a process that recognises and builds on the position of the NHS as the primary source of medical expert witnesses;

- that medical expertise is tailored and prepared for the particular culture of the family court (public law) jurisdiction with its aim of using a largely inquisitorial system;
- a framework that enables issues of competence, performance and conduct of individual experts to be tackled proportionately;
- an organisational framework within the NHS with clear accountability for medical expert witnesses and which therefore moves supply away from the current reliance on medical expert witnesses who are acting in a private capacity.

The approach in this report

1.14 My report aims to:

- describe the role of the medical expert witness in public law Children Act proceedings;
- analyse the key issues and challenges in the system of provision to the courts and make the case for change;
- set out proposals for improvement to meet the vision described here.

Chapter 2
The medical expert witness in court proceedings

2.1 An expert witness, in whatever field, is someone who, because of their particular qualifications, knowledge and/or skills, is able to assist a court in its deliberations. The knowledge and information that an expert can bring to a case is beyond that of a layperson. Medical expert witnesses can and do appear in the criminal courts (when someone is being tried for a criminal offence), in the civil courts (eg in cases of medical negligence), as well as in the family courts. This report focuses on the last of these, and in particular on the use of experts in public law childcare proceedings (ie those brought under Section 31 of the Children Act 1989). Some of the issues covered in the report, such as the quality of expert witnesses, apply to medical evidence in all the different court settings.

2.2 Doctors also act in court cases as 'witnesses of fact', in other words, as the doctor who treated or is treating the individual concerned. Many Children Act cases are settled on this type of evidence. There is no need in such cases to bring in an independent additional expert witness. It is sometimes assumed that a 'witness of fact' should not provide an opinion on 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 'witnesses of fact', which can also include social workers involved with the family, can reduce the demand for independent medical expert witnesses.

2.3 Experts in public law Children Act proceedings include not only doctors but also other specialists such as social workers. In this report, the term 'medical expert witness' describes a qualified doctor who produces a report for the courts (after the magistrate or judge concerned with the case has agreed the need for the report) and may then appear as an expert witness in court. The expertise derives from doctors' qualifications and experience rather than their eminence. Medical experts may undertake assessments of evidence or of people, including children, and provide explanations for medical conditions and behaviour. They may be asked to provide opinions on the likely effect of treatment and the potential for change in an individual's behaviour or condition. This report does not consider the preliminary activities undertaken by local authorities in seeking medical advice to establish whether there is a case to be heard.

The court process

2.4 Public law Children Act proceedings consider the welfare of children who are suffering or are likely to suffer significant harm and may be at risk, and this may involve medical expert witnesses. The steps to be followed in childcare proceedings are set out in the *Protocol for Judicial Case Management in Public Law Children Act Cases*. These steps are summarised at Annex B. A flowchart illustrating the process is shown at Figure 1. The protocol was adopted in November 2003 and is currently under review.

2.5 It is the job of the family courts in these proceedings to decide, first, whether or not the child concerned is suffering or is likely to suffer significant harm (from physical, sexual or emotional abuse, or neglect) ie the 'threshold' stage. If this threshold is proved, then the courts must decide whether to make a care or a supervision order ie 'the disposal stage'.

2.6 Proceedings take place in the Family Proceedings Courts (Magistrates' Courts), in Care Centres (County Courts) or in the High Court. Experts, including medical experts, can be involved at all of these levels. In general, the more complex the case and the more experts involved, the more likely the case is to be heard at a care centre or in the High Court.

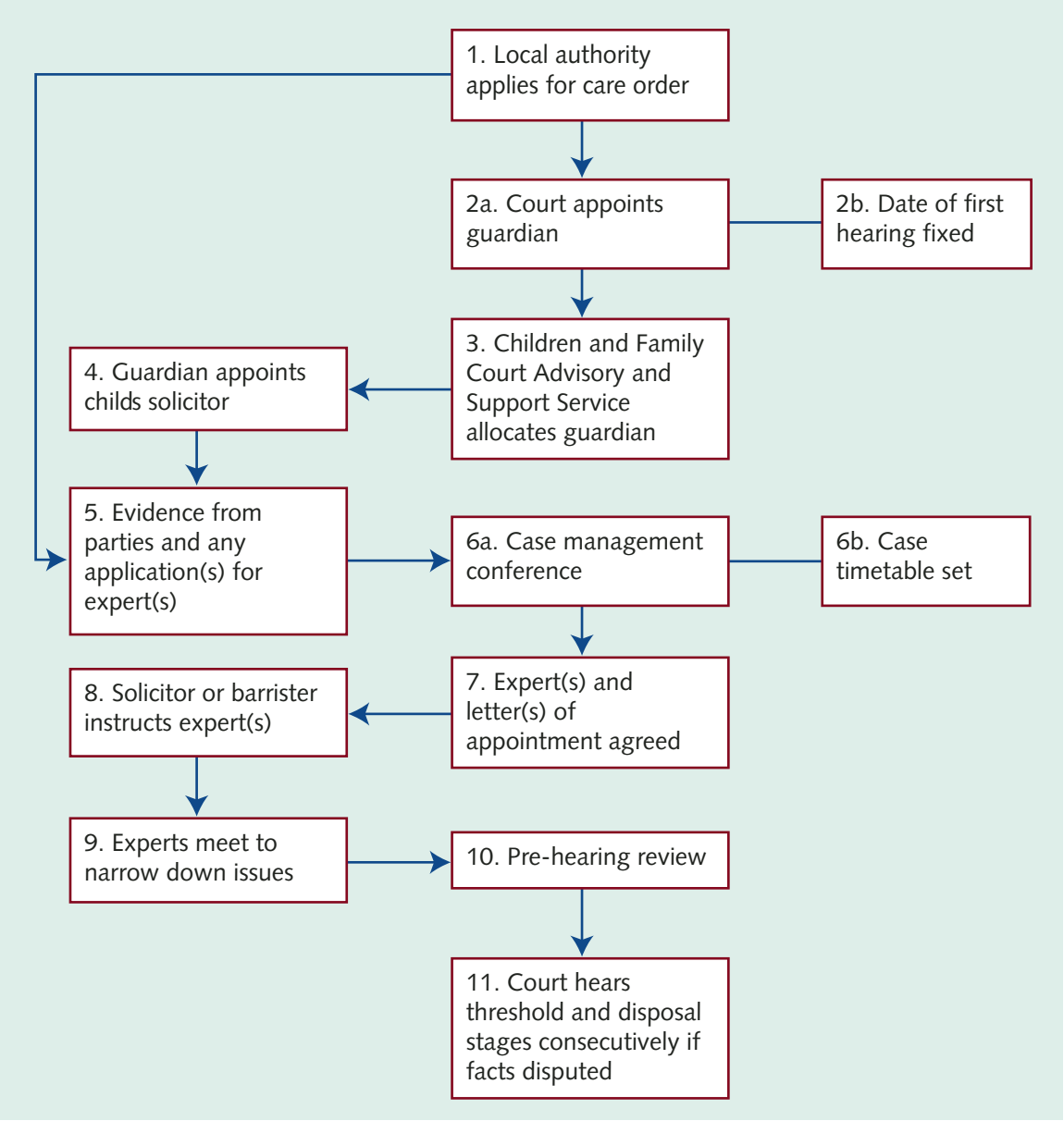
2.7 A medical expert witness' role is similar in the different settings of the family court but experts from different medical specialties may be involved at different stages of care and supervision proceedings. Paediatricians, child psychiatrists and clinical psychologists specialising in children may be involved at the 'threshold' stage, where the focus is on the child and whether he or she has suffered harm. Adult psychiatrists/clinical psychologists are more likely to be involved at the 'disposal' stage, for example to assess the parents' ability to care for the child. In a very small number of cases, often heard in the High Court, a whole range of medical specialists may be required (eg radiologists, ophthalmologists, neurologists, urologists) but this is unusual. In the overwhelming majority of cases, it is agreed by the parties that there should be a single joint expert to report on the medical evidence. All the parties (the parents, local authority and representatives of the children) then have a say in the instructions provided to the expert, usually through the child's solicitor, and may question him or her on the report at the hearing.

2.8 The family courts also deal with private law proceedings, such as disputes between parents over contact with children and residence. This report is not concerned with private law proceedings in the family courts. (However, the court has the power, in any family proceedings in which the welfare of a child is being considered, to direct a local authority to undertake an investigation and consider whether to apply for a

court order. Some private law cases therefore become public law proceedings.) Nor is this report concerned with other settings in which medical expert witnesses may provide evidence, such as the criminal or civil courts or mental health tribunals. I recognise that similar issues of supply and quality of experts can arise there, as in the family courts, but my proposals will entail considerable change and new ways of working. The necessary changes should be allowed to bed down before any consideration is given to extending the system to other types of case or types of court.

2.9 In the meantime, those courts that require evidence from paediatricians, psychiatrists and psychologists will benefit indirectly from these proposals, as they will lead to a greater pool of trained and experienced expert witnesses.

Figure 1: The expert in the family court



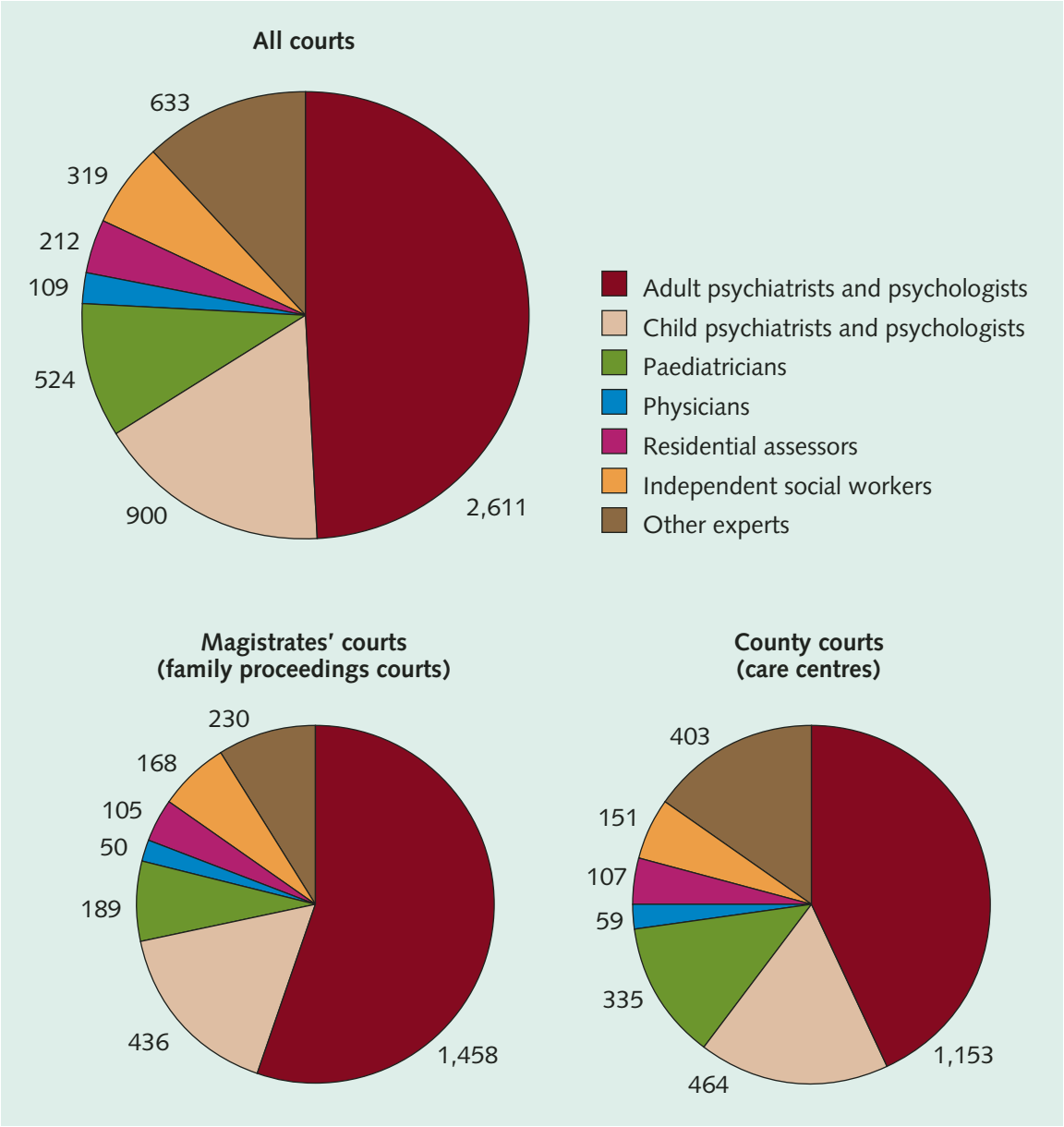
2.10 Around 200 Family Proceedings Courts and 55 Care Centres deal with over 10,000 public law childcare cases a year in England and Wales. The estimated increase in the volume of cases is about 4% a year over the last few years. All public law family cases begin in the Family Proceedings Court and half the care orders are completed there (the proportion has fallen in recent years, because more cases are being referred to the higher courts).

2.11 Anecdotal evidence suggests more, but estimates made by the Department for Constitutional Affairs show that around 25% of cases involve experts. In these cases, there is an average of approximately two experts (1.7) per case, typically a paediatrician or child psychiatrist at the 'threshold' stage and an adult psychiatrist at 'disposal'. This estimate may be subject to revision in the light of experience and a perceived trend towards the greater use of and demand for experts.

2.12 By far the largest proportion (between 70% and 80%) of experts involved in public law Children Act proceedings, in both the magistrates' courts and the higher courts, are medical experts (Figure 2).

2.13 Medical experts charge a fee, usually by the hour, but sometimes for the case as a whole. The cost of experts' fees is met by the parties to the case (the local authority, the children and the parents). In practice, the overwhelming majority of public law Children Act cases are entirely publicly funded, since the parents' costs and those of the child or children are often provided by legal aid, through the Legal Services Commission. No accurate data are collected on the total costs of medical expert witnesses in public law childcare cases. However, based on a number of assumptions and estimates made by the Department for Constitutional Affairs (including a cost of experts per case – averaged over all cases, including those involving no experts – of £2,229), the cost of all experts in these cases is thought to be around £20 million per year. This is 6% of the total costs to public funds of these cases.

Figure 2: Number of experts used in public law cases, 2004



Source: Department for Constitutional Affairs. See Annex C for the detailed data.

Chapter 3
Key issues and challenges

3.1 I commissioned a survey to collect information on the experience and attitudes of doctors who have acted as expert witnesses and those who have never done so. Paediatricians, child psychiatrists, adult psychiatrists and clinical psychologists are the clinical specialties most often needed to provide expert evidence in family law cases. The internet survey, conducted by the organisation doctors.net, was limited to the medical specialties, as the database did not include clinical psychologists. Due to the specialty quota system operated by doctors.net, a total of 358 fully completed surveys were returned after an initial screening-out questionnaire involving 997 clinicians. This was not a large number of returns, nor was there a random sample, but the survey is the only current source of evidence on many of the issues. General themes were picked out from the results to improve understanding of participation and influences on decision making in this area. The questionnaire and results of the survey are being published alongside this report. A number of key findings are highlighted below, the first of which derive from the initial 997 respondents:

- Of the initial 997 respondents (all grades of doctors), 53% of child psychiatrists, 58% of adult psychiatrists and 80% of paediatricians did not act as expert witnesses (Table 1).

Table 1: Percentage of doctors by specialty in medical expert witness work

	Specialty		
Status	Paediatrics (n=588)	Adult psychiatry (n=307)	Child psychiatry (n=102)
Currently acting	15%	31%	28%
Used to act but stopped	4%	11%	19%
Never acted	80%	58%	53%

Note: Figures may not sum to 100% due to rounding.

- 'Never being asked' was the most important reason given by respondents of all grades, including consultants, when asked why they did not act as medical expert witnesses (Figure 3). Specialist registrars also said they felt unqualified.

- Those clinicians not currently acting as an expert witness were asked what, if anything, would make them willing to do so. A few respondents indicated that nothing would persuade them to do so. A number also said that they would do so if they were asked. A large proportion mentioned the need for training for them to feel qualified:

  "An introductory course designed to prepare one adequately to act as a witness."

  "Training and advice from legal professionals. If I could have advice on how the report needs to be written and what the courts are looking for."

- Other important reasons quoted included the need for support from others:

  "I'd be more than happy as long as I felt supported by my peers, department, NHS employer and the legal team involved to undertake this work."

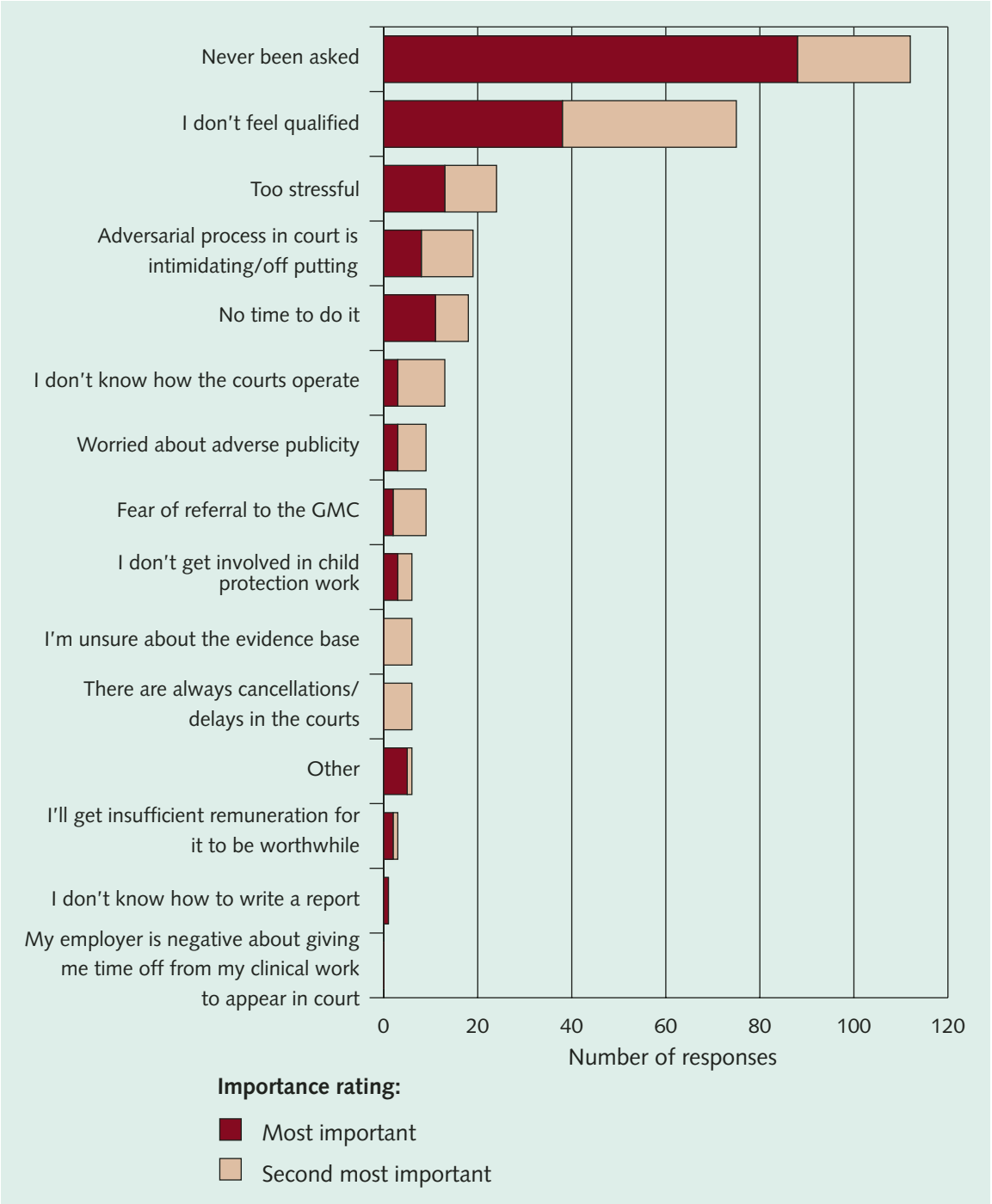
- Some explained what would make them willing to act as experts:

  "Complete protection from litigation as a result of this work, if opinion is given in good faith and represents my honest professional opinion."

  "If I thought that there was acceptance that expert witnesses are fallible, but do their best in the light of what they know. I do worry that I may be taken to task for things that require the wisdom of Solomon. I think I may be too worried about this, but possibly do not have the personality to do well in cross-examination. I do think I have the skills and knowledge to write a good report."

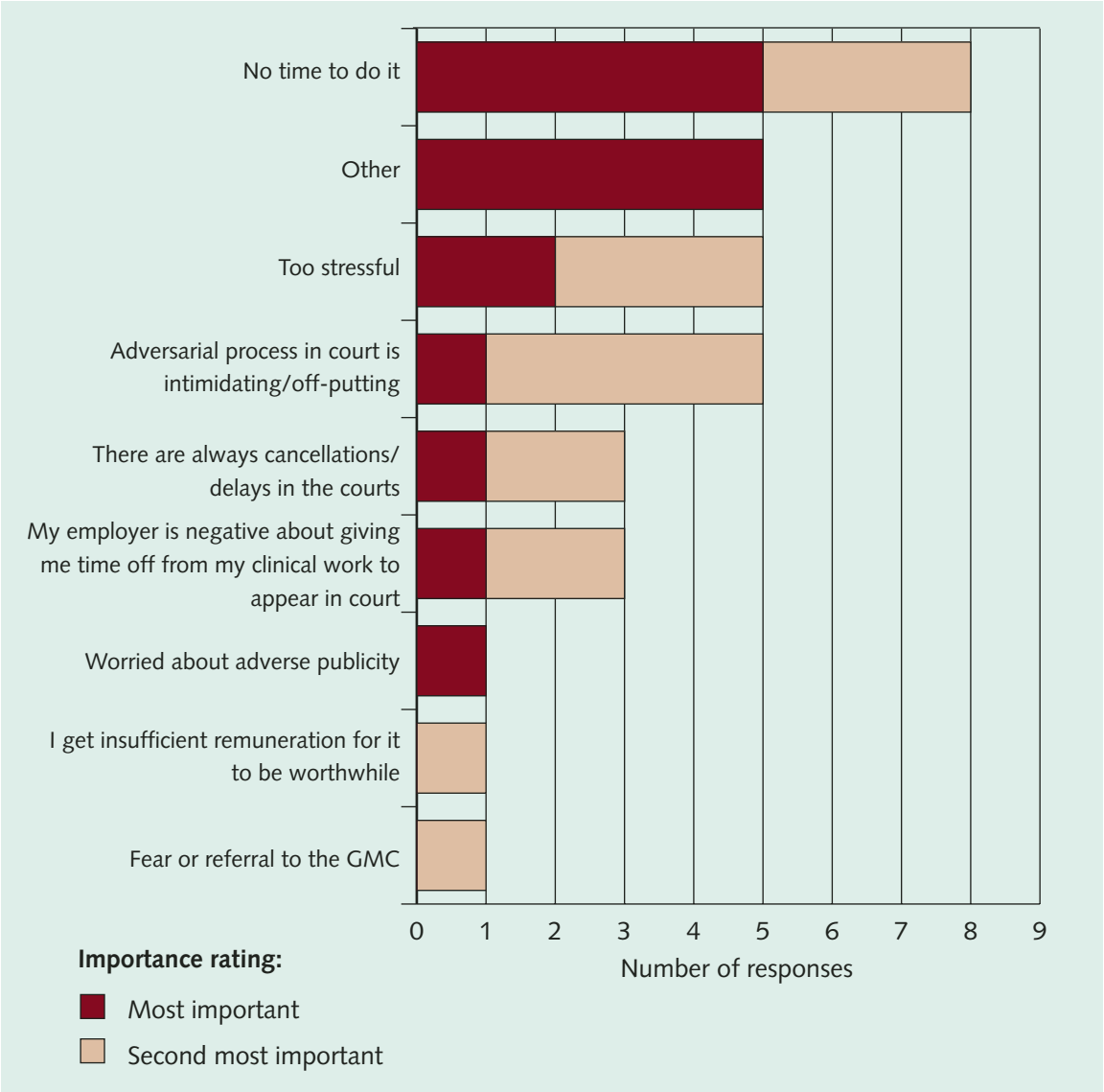
  "There would need to be a better climate of accepting that, in this role, doctors are only giving their opinion and doing the best they can on the evidence presented to them. We are only human and don't know everything. I think the risk of your integrity as a doctor being publicly destroyed and the effect that this has on all aspects of your life is too great a risk and when things go wrong there seems to be no understanding that the doctor was only doing their best."

Figure 3: Reasons for never having acted as an expert witness (n=177)



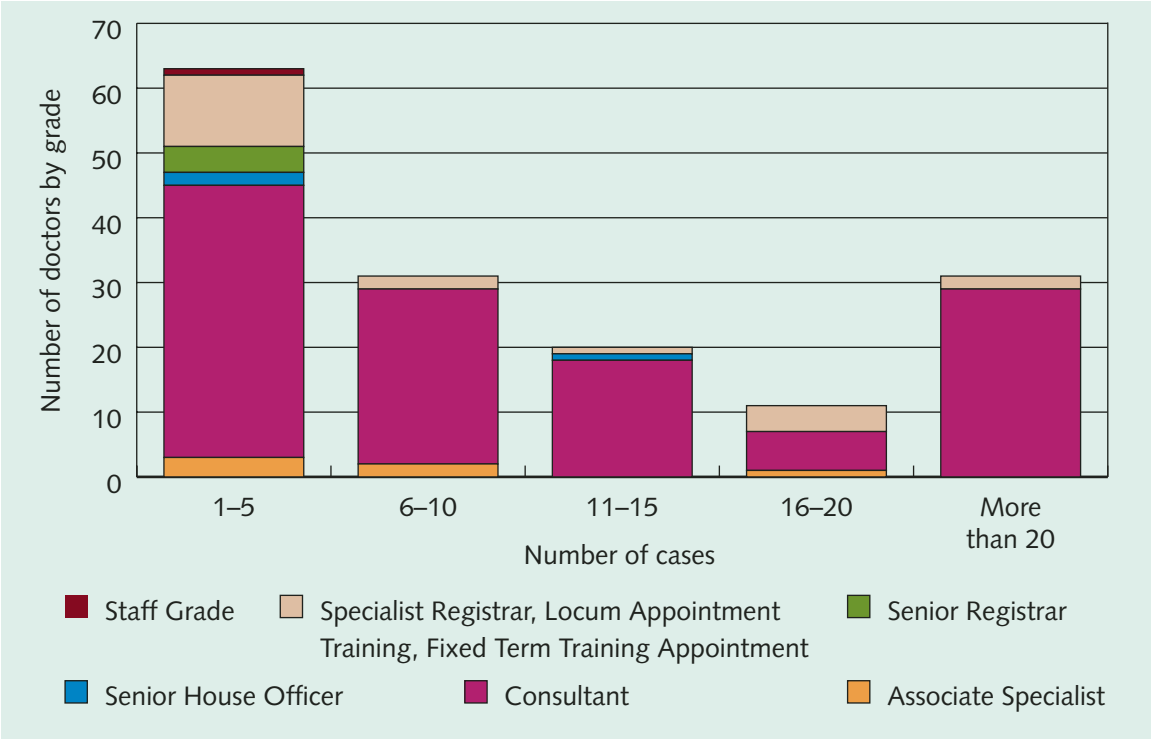
- For the 25 doctors in the survey who had acted as medical expert witnesses in the past, the most commonly given reasons for stopping were 'a lack of time' and finding the experience 'too stressful' (Figure 4); other factors cited in relation to those who had previously acted as expert witnesses in the family court included 'cancellations/delays in the courts' and 'intimidating adversarial process'.

Figure 4: Importance of reasons for stopping work as an expert witness (n=25)



- For those currently acting as medical expert witnesses, the survey suggests that:
  - almost all have an NHS contract but a much smaller proportion undertook medical expert witness work within their NHS contract (although for paediatricians this amounted to 65% – more than double that for psychiatrists);
  - the largest proportion (40%) had acted relatively infrequently (between one and five times in the past five years) but a number of them (20%), had acted as an expert witness more than 20 times in the previous five years;
  - over three-quarters (78%) were consultants, with the next largest professional group being specialist registrars (Figure 5);

Figure 5: Number of cases in last five years for currently acting court witnesses, by professional grade (n=156)



  - as Figure 2 shows, half of the experts used in family law cases are adult psychiatrists and psychologists;
  - of cases reported in the survey, just under half (42%) were attributable to adult psychiatrists acting in civil cases and just three doctors accounted for almost half of the cases in which adult psychiatrists were involved.

- Table 2 sets out the average caseload per type of case (family, criminal or civil) by specialty, expressed as a ratio. For example, among the child psychiatrists who responded, the average number of cases per doctor was 12 in family law, 11 in criminal law and 9 in civil law proceedings. In understanding these figures, it is important to note that the sample may not be representative, and that a small number of doctors within the child psychiatry/criminal case category and within the adult psychiatry/civil case category account for a large number of cases.

Table 2: Ratio of medical expert witnesses to cases by specialty of respondents currently acting as medical expert witnesses (n=215)

Type of case	Paediatrics	Adult psychiatry	Child psychiatry
Family	1:7	1:21	1:12
Criminal	1:5	1:17	1:11
Civil	1:19	1:72	1:9
Total	1:9	1:36	1:11

- In all, 59% of paediatricians who responded, 37% of the adult psychiatrists and 23% of the child psychiatrists had received no special training to allow them to be an expert witness.
- The training that these witnesses had received varied considerably. In one case, the doctor concerned told us it consisted of a lecture from the county solicitor; in other cases, respondents had attended one or more courses of three or four days' length.

"Two-day training on being an expert witness as part of specialist registrar training, with preparation of report and role-playing in court with a real magistrate, and with presentations by colleagues who regularly act as expert witnesses. First two expert witness cases were performed as a specialist registrar with direct supervision from a consultant with experience. Opportunity to shadow High Court judge for several days in Family Court, whilst in specialist registrar grade."

"The training programme director who does a lot of work in the family courts organised special training days and a pupillage scheme. One day involved attending court as a group with a mock court hearing aided by a guardian ad litem and a local magistrate as the presiding judge. We also took part in a court pupillage scheme where we spend a day in the family courts with the judge, both in chambers and in court."

"Report writing course twice. Child protection course at [a named] hospital included expert witness skills. Work closely with colleagues and share all reports before sending. Supervision from senior colleagues."

3.2 A number of doctors, who were generally acting or had acted as expert witnesses themselves, were interviewed in the process of gathering evidence for this report. Their motivation varied: some were clearly attracted by the opportunity to increase their income by doing the work in their own time; others saw the task as part of their normal job and carried it out within their normal NHS contract. Many questioned why acting as a medical expert witness in care and supervision cases should be seen as 'private' work and therefore separate and outside of their usual child protection responsibilities. Those who were doing the work in their own time were often doing so because they felt it was part of their public duty; but they said they felt isolated and unsupported because the activity did not involve their normal colleagues and normal support networks.

3.3 Many of these clinicians were aware, from personal experience, of the problems of supply of medical expert witnesses because the number of requests they received to be an expert witness far exceeded their capacity to do the work. This is confirmed by the survey which showed that doctors currently acting as witnesses turned down almost as many cases (15.9) as they expect to undertake (16.2) each year. Those interviewed also highlighted the amount of time spent travelling to give evidence in court in a distant part of the country and that timescales and rescheduling of hearings could also be problematic.

3.4 Some of the doctors who were interviewed mentioned that lawyers' instructions could be too broad and general, making it difficult for them to produce a focused expert report, for example:

"Tell us everything you know about this child."

3.5 Some of the instructions they were given were very good, but the quality of instructions was very variable. This was echoed by some of the comments made in the survey, when respondents were asked what would make them more positive about being an expert witness:

"Clear and appropriate instructions."

"Clarity of instructions (along 'Woolf' lines)."

"More consistent provision of information and instructions from solicitors, without me having to tell them how to convey to me proper instructions from the court."

3.6 Discussions with judges, barristers, solicitors and magistrates seen during my work suggested a general level of satisfaction with the reports and evidence given in family cases by the majority of medical expert witnesses with whom they had come into contact. They also emphasised:

- the importance of the expert's independence and responsibility to the court, and that steps should be taken so that parents do not perceive the expert to be against them;
- the need to draw on and spread existing good practice within the system, for example medical experts working in multi-disciplinary teams within the NHS;
- the need for a clearer definition of the skills and competences required by experts.

3.7 All key stakeholders were aware of the difficulties in identifying a suitably qualified medical expert who was available to assist the courts in Children Act proceedings within a reasonable timescale. Monitoring data from the Department for Constitutional Affairs show that, of more than 5,000 instances of delay identified in family proceedings in 2004, 12% were caused by lack of availability of expert(s) or by delay in the submission of their reports. In some cases, it was clear that there were limits to the overall capacity in particular specialties, particularly in child psychiatry, paediatric pathology and paediatric radiology, and this echoes concerns within the NHS about problems of recruitment to some key clinical specialties. Lawyers also reported that clinicians who were willing and able to be an expert witness were very busy with a large number of childcare cases and were often not able to agree to do the work within the timescale laid down in the Protocol (Annex B).

3.8 The interviews with stakeholders and the findings from the survey provide clear pointers to what should be done to deliver a sustainable supply of medical expert witnesses for the future and ensure the quality of the evidence they provide. In particular, there is a need to:

- build on the feeling of many clinicians that work which protects vulnerable children is important to society and is a public service;
- find a means of spreading the workload widely, and ensuring that those who have never been asked to be an expert witness and would be willing to do so are helped to take on the work;
- design a system which encourages the supply of expert witnesses to grow, by training younger doctors so that, as experienced consultants retire, others are able to replace them;
- develop training programmes to ensure that everyone acting as an expert witness or a witness of fact is equipped, and feels qualified, to do so;
- reinforce the independent status of expert witnesses and their responsibility only to the court;
- improve court processes generally, so as to reduce the delays and cancellations of hearings which can disrupt doctors' clinical work and make it difficult for them to give evidence in person.

Chapter 4
Proposals for an improved medical expert witness service

Proposal one: Providing medical expert 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.

4.1 The Children Act 2004[25] places a statutory duty on the NHS to have regard to the need to safeguard and promote the welfare of children when discharging its functions. The provision of expert evidence by clinicians in public law care and supervision cases, which arise because the welfare of one or more children is at risk, and which are almost entirely publicly funded, is closely linked to this duty. Such work should therefore support the child protection (public) service rather than being private, fee-paid work, and the NHS should regard it as a core component of their work. In this respect, care and supervision proceedings differ from other work by medical expert witnesses, whether in criminal or civil cases.

4.2 It is also clear to me that any recommendations for increasing the supply of medical expert witnesses to the family courts should focus on the major source of potential supply, which is the NHS. As the survey clearly shows, almost all paediatricians, child psychiatrists and adult psychiatrists (the main professional groups needed as experts in public law childcare proceedings) who acted as an expert witness were employed in the NHS.

4.3 Consultants working in the NHS already possess the medical skills needed to help vulnerable children. Specialist registrars are being trained to acquire those skills and that experience. Those senior clinicians who do not currently act as expert witnesses could be helped to acquire the skills needed for work with the courts, and those more experienced could be enabled to support them in this role as well as to train more junior doctors to take on this work in due course.

Proposal two: NHS Trusts, Foundation Trusts and Primary Care Trusts (referred to in this report as NHS organisations) with substantial paediatric, child psychology and psychiatry and/or adult psychology and psychiatry services, should provide medical expertise to the Family Courts through the formation of groups or teams of clinicians within the same specialty or on a multi-disciplinary basis. Teams may include other specialists from within the trust, for example, radiologists or ophthalmologists who may act as witnesses in family law cases, and clinicians who have retired within the last two years from active clinical practice. In time, such groups or teams in adjacent NHS organisations may form managed local networks[26] to enhance the viability of their services, specialisation and spread of expertise, and to share their resources and training more effectively.

Proposal three: The main contract or service level agreement for providing medical expert evidence to the family courts within a particular area should, in future, be held by one or more NHS organisations and delivered by specialty or multi-disciplinary teams, rather than by individual named clinicians. This would not preclude parties to a case asking for an expert from outside the area or for one working as a private individual.

4.4 In order to deliver this service effectively and ensure a sustainable quality supply of clinicians capable of doing the work, it will be necessary to change both the current supply and commissioning arrangements. At present, these involve a lawyer, usually a solicitor – the representative of a private business – contracting with an individual medical expert witness, often one they have used before. The focus on a single clinician, who has already acquired the necessary skills and experience to work in the courts, may well lead to evidence of high quality. However, it militates against extending the pool of people who potentially could be involved as medical expert witnesses, limits peer review and reduces the visibility of such work in medical team practice. The challenge, therefore, is to maintain high standards of evidence whilst ensuring that more clinicians are able to provide evidence of that quality.

4.5 Such an approach, where medical expert witnesses work for the family courts in groups or teams, is already taken in some NHS Trusts; for example, in paediatrics at Norfolk and Norwich University Hospital and in child psychiatry at Great Ormond Street and the Marlborough Family Clinic. As well as reflecting routine ways of working within the NHS, this approach would have a number of added advantages, namely:

- building the work into employment contracts and job plans;

- allowing all members of the team to gain experience of the processes of analysis, assessment and report writing, which are essential for work as a medical expert witness;
- developing these skills under the leadership of one or more trained and experienced consultants;
- securing quality assurance through ongoing supervision by experienced members of the team and peer review;
- making it a part of mainstream clinical activity so that it is an integral part of clinical governance, appraisal and peer review;
- giving more reassurance, to the courts and to the parties, that the evidence provided is based on a consensus of medical opinion;
- allowing the right medical specialty needed for a particular case to be more easily identified because clinicians in an NHS Trust will be able to suggest the involvement of other sub-specialties where this seems necessary;
- providing support and advice to colleagues from the same institution who are called to act as a witness of fact;
- introducing a system that is both manageable and, unlike the current system, capable of being monitored.

4.6 Although not widespread in the NHS, the key features of existing specialty and/or multi-disciplinary teams are:

- a mix of doctors from various specialties, and other professions such as clinical psychology, social work, family therapy and health visiting – the optimal size seems to be between six and 12 team members;
- the lead role on each piece of expert witness work is allocated by the team leader to the most appropriate person in the team, which may be someone who is not of consultant grade;
- the members of the team discuss their current cases and particularly any issues where views on causation of harm to the child may differ;
- work by junior members of the team is supervised and corrected as necessary by someone who is more senior and experienced in expert witness work.

4.7 Individual clinicians interviewed, who are members of groups or teams, emphasised the importance of their leadership and mentoring function for specialist registrars joining the team, and their responsibility for helping junior colleagues to gain experience of the work of being an expert witness based on real situations and cases.

They also emphasised that the groups with which they were involved provided collective responsibility for the work. The process of discussing the cases for which they had to produce reports within the team ensured that all aspects of the case were covered and that knowledge of similar cases and the basis of evidence was pooled – this ensured a higher quality outcome and avoided the risk that the perspective of one individual might be given too much weight.

4.8 If such arrangements were in place locally – so that expertise is generally provided by one or more of the participating NHS organisations within the Local Justice area – they would introduce the safeguards that come with local clinical governance arrangements and provide opportunities for longer term interdisciplinary learning and feedback led by the newly established local Family Justice Councils. A locally based system would also help to avoid some of the current problems, particularly in child psychiatry, in which the report for the court, produced away from the area in which the child is living, can recommend therapeutic interventions that cannot be provided by the NHS in the child's home area. It would make it easier to find the necessary expert, because there will be a known point of contact within each NHS organisation in the area. Travel time for the medical experts would also be reduced. In time, teams of medical expert witnesses located in adjacent NHS organisations may consider forming managed local networks in order to complement scarce expertise and share training resources. Managed local networks are linked groups of health professionals within and across NHS provider organisations who work together in a co-ordinated manner to deliver specialised services.[26] They differ from other types of partnerships in having clear clinical governance and accountability arrangements. Other benefits of such networks include working to common standards across organisations, thereby reducing variation in services and providing a single point of access to a wider range of expertise.

4.9 Seeking medical expertise for the courts from local NHS organisations would build on the fact that, in most cases, a single jointly instructed source of expertise is appropriate. It would not prevent the instruction of further experts, perhaps from a neighbouring area or further afield, where the magistrate or judge approves an application from one of the parties for another independent expert to be used, or where very specialist expertise is only to be found in another area.

4.10 For this new approach to succeed requires that the task of providing the medical expertise is given to the group of clinicians as a whole, rather than to a named individual. There would need to be a willingness by the courts and by solicitors and barristers to move away from the system of using a named individual expert, towards a system in which quality assurance is provided by the expertise and experience of the leader of the team, by the NHS as employer and by the involvement of several people in the work of producing reports for the courts. The individual who writes the report,

and who may need to give oral evidence, would be selected, not by a lawyer but by the leader of the team, according to the complexity of the issues and the experience of the person concerned. It would also be for the leader of the team to decide which members should be involved with each case, and it would need to be understood that information relevant to the case would be shared between members of the team.

4.11 Clinicians who have retired within the last two years from active clinical practice have valuable skills which NHS organisations may wish to use in expert witness teams. Those who have experience of being an expert witness may be able to act as mentors to clinicians who wish to develop the necessary skills. There is no barrier to NHS organisations re-employing clinicians who have recently retired (within the last two years), although this can affect pension payments in certain cases and the position should be checked for each individual involved.

Proposal four: NHS Human Resources teams in participating trusts should include an assessment of the workforce implications for their trust in their development plan and, in particular, should include an assessment of the long-term staffing needs and a plan to build up the workforce.

Proposal five: Regional Directors of Public Health should co-ordinate implementation of the proposals that relate to the NHS. The Department for Constitutional Affairs, the Department for Education and Skills and the Department of Health, working with the Family Justice Council, could oversee and report progress on all aspects of implementation.

4.12 Implementing these proposals will take time. Some NHS organisations should be able to provide a partial service for the courts in their area relatively quickly, because their staff already include a number of clinicians with the relevant skills and experience of working with the courts. In others, however, there will be no one available to take on the role of leader of the proposed group or team. In these cases, more training and help will need to be provided before the group can function effectively. Workforce planning and development of expertise are essential to the process, and it should be part of the task of human resources teams in each participating organisation to assess their staffing needs and make plans to build up the workforce.

4.13 If the proposals in this report are accepted, co-ordination of implementation within the NHS could be taken forward by Regional Directors of Public Health. They are well placed to manage the planning of this system. An early task would be to map the current distribution of those who act as medical expert witnesses, whether in paediatrics, child or adult psychiatry or psychology, within and between the 38 new court administration areas in England. This will allow the identification of those

NHS organisations able to move forward more quickly. In others, initial training and help will need to be provided which will have some resource implications. These, however, cannot be quantified until the mapping exercise has been carried out.

Proposal six: The costs for the NHS in taking on this additional workload and in training and development to deliver a quality supply of medical witness expertise in the future should be fully met (currently the cost of experts is shared by the Legal Services Commission and local authorities).

4.14 Steps will also need to be taken to establish from Local Justice areas of the Department for Constitutional Affairs and local authorities in each of the 38 areas in England, the likely workload that NHS organisations would be required, in due course, to manage. Estimates of caseload and use of experts made by the Department for Constitutional Affairs suggest that NHS organisations in each of the 38 court areas in England would need to provide around 100 expert reports a year, resulting in court appearances in about 25 cases. To develop expertise, the work should not be spread thinly across a large number of NHS organisations, and study of those teams which are already operating suggests that an annual caseload of around 30 reports per team is appropriate. This suggests that there might be three or four teams of medical experts in each court area (equating to perhaps 12 to 14 teams in each NHS Strategic Health Authority area). Local authorities hold detailed figures of the number of applications for care and supervision orders they make and the number of expert reports funded each year. This information will need to be analysed locally to allow more precise estimates of future workloads in each area to be made.

4.15 In the longer term, NHS organisations may be expected to take on most of the caseload for public law Children Act proceedings. As their capacity grows, the need for individuals to act as expert witnesses in the family courts in a private capacity will decline. However, the parties to a case will continue to have a choice of expert, subject, as now, to the approval of the judge or magistrate – including those acting in a private capacity or working in private hospitals.

4.16 Medical expert witness work within the NHS will need to be properly resourced on a continuing basis. NHS organisations are currently staffed and funded according to the healthcare workload they have to do, which does not, in most cases, currently include work for the courts. Almost all public law Children Act proceedings are entirely resourced from public money, whether from local authorities or from the Legal Services Commission through legal aid. The resources for medical expert witnesses will need to flow into the NHS to cover the additional workload and training to be taken on by the medical expert witness teams which I am proposing (and should, if allocated directly to the teams involved, allow them to develop additional capacity).

4.17 It is not of course, intended that the NHS, which is a public service, should 'profit' from providing medical expert witnesses to the courts but the NHS must be resourced to cover the additional costs of this work, including training. In due course, I would anticipate there would no longer be a need for public funds to pay the very high fees that are currently charged by a few medical expert witnesses.

Proposal seven: Funding of medical expert witness work from the NHS should be on a basis of an agreement on the service to be provided, its cost and volume, in line with most NHS activity to ensure proper workload and workforce planning.

4.18 The work of NHS Trusts is almost all funded on a block contract basis, in other words, covering an estimated number of cases over a future period. This will change in due course as a new funding regime is implemented across the NHS. The funding of medical expert witness work by the NHS should be developed in line with this and it is important for funding flows to have some certainty so that NHS staffing needs may be planned and recruitment may take place in advance. It would not be feasible for NHS organisations to provide all medical expert witness evidence on an ad-hoc basis, from single contracts with individual private solicitors. This would not allow the organisation concerned to estimate its future workload or to provide timely reports for the courts.

4.19 In addition to providing expert witness expertise under their main contract or service level agreement in the area in which they are based, NHS organisations may also accept one-off requests to provide an expert report in a family law case. For example, where a specialist expert is not available in the area concerned. Alternatively, where the court has decided that the expert report should have been provided by the local authority at the outset of proceedings, when the authority would therefore pay for it.

Proposal eight: The views of key stakeholders should be sought on which public sector organisation is best placed to commission the medical expert witness service from the NHS.

4.20 If the NHS is to become the main source of supply for medical expert witnesses in family proceedings, a public sector organisation must be in place and be competent to contract or enter into a service level agreement with the NHS to provide this future service. NHS organisations are staffed and funded through forward contracts according to their likely healthcare workload. Unlike spot purchasing by individual lawyers, this allows the staff to be recruited and trained, and available in post to do the work when needed. Under such forward contracts, the commissioning

organisation agrees to provide funding each year for a certain workload – in the case of medical expert witnesses, this could be for a certain number of reports to the court each year, a certain number of court attendances, and any reports and/or attendances needed above this number could be negotiated separately.

4.21 The commissioning organisation for medical expert witness work should be experienced in commissioning, be independent of any of the parties to the proceedings and have a local or area presence. This would enable contracts or agreements with NHS Trusts in each area to reflect the workload of the family courts in that area. There will be staffing and training implications for any organisation which takes on the commissioning role; in contrast, the workload of solicitors who enter into contracts with expert witnesses on a case-by-case basis would reduce.

4.22 I have identified four organisations which could commission medical expert witness reports in future:

- **The Children and Family Court Advisory and Support Service** (CAFCASS): As the professional guardian of the interests of the child, CAFCASS already appoints the child's solicitor who is often the 'lead solicitor' for the majority of cases where the medical expert is jointly instructed by all of the parties. However, as the guardian of the interests of one of the parties only, CAFCASS could be seen as too partisan to act as the commissioning organisation.
- **Her Majesty's Courts Service** (HMCS): The administrative staff employed in HMCS to support the work of the courts in each local area are part of the Department for Constitutional Affairs. Making HMCS the commissioning organisation would emphasise that it is the court which requires the expert's report in order to carry out its responsibilities. However, HMCS staff could not have such close involvement in the conduct of individual court cases without breaching the important constitutional doctrine of the separation of powers, which maintains a distinction between the work of the judiciary in deciding cases and the work of the executive, including administrative support. HMCS could only act as commissioner of evidence in individual cases if it was made into a separate organisation (a non-departmental public body). This would require primary legislation and would have wider consequences. Prior consideration would need to involve work on the costs of such an exercise in relation to any perceived benefits.
- **The Legal Services Commission** (LSC): The LSC administers the legal aid budget which funds most of the cost of medical experts and other expert witnesses. As a non-departmental public body, it could commission the service from the NHS as a neutral party. It also has a regional presence but may be seen as too remote from activity in the courts at local level.

- **Primary care trusts**: PCTs already commission services from NHS trusts to meet the health needs of their local population. Primary legislation would be needed to enable them to commission reports for the courts. Since PCTs are part of the NHS, giving them the commissioning role may make the parties feel forced to use NHS services for expert witnesses, and therefore could be seen as limiting the choice of the parties to appoint, subject to the approval of the judge or magistrate, an expert from a private organisation or one who is working as an individual. Another drawback is that PCT funds are not 'ring fenced' for particular purposes.

4.23 All of the organisations that could commission the service have both advantages and disadvantages. I should like the views of stakeholders on which commissioning organisation would best serve the purpose.

Proposal nine: When the commissioning organisation has been determined, consideration should be given to whether there is scope to rationalise the funding system for expert witnesses used in public law Children Act proceedings.

4.24 The functions of commissioning a service from an expert and that of instructing are distinct and need not be carried out by the same person, but currently are. I believe that an organisation commissioning a service from the NHS should, ideally, also be responsible for specifying how that service is provided and at what cost. This would suggest that the commissioning organisation could also be responsible for instructing the experts and for paying their fees. This could act as an incentive to experts to provide impartial and clear evidence and timely reports. There could also be savings with administration, handling and legal costs. However, changing the ways in which instructions are provided by solicitors and the funding flows is not necessary at this stage and may prove too complex to implement quickly.

4.25 At present, local authorities are responsible for gathering evidence in childcare proceedings to enable them to put their case to the court. This may include experts' reports, which will continue to be provided, and funded, as now. My study has been concerned with the appointment and instruction of medical experts where the judge or magistrate has agreed to an application from the parties that such an expert is needed. In these circumstances, the fees paid to expert witnesses are almost all met by public funds, and are claimed back by the instructing solicitor from the Legal Services Commission (as legal aid) and/or the local authority. When it has been decided which organisation should commission medical expert witness services from the NHS, I propose that consideration be given as to whether there is scope to rationalise the current funding system.

Proposal ten: The Law Society, in consultation with the Academy of Medical Royal Colleges and the General Medical Council, should consider how the quality of instructions to medical experts might be improved and should disseminate information to their members.

4.26 Some of those interviewed during the course of this study emphasised that there was scope for improving the instructions provided to medical expert witnesses. One way of achieving an improvement would be to concentrate the role of providing instructions in fewer places than now. This would ensure that those providing instructions would gain experience of writing the sort of instructions that experts find helpful and which will meet the needs of the court. However, pending future possible rationalisation of the system of providing instructions, I propose that the Law Society, in consultation with the medical Royal Colleges and the General Medical Council, should be asked to consider how the quality of instructions from solicitors to medical experts might be improved and to disseminate information to their members.

Chapter 5
Proposals for quality assurance

5.1 Education, training, accreditation and regulation are essential elements in the supply of competent, quality-assured medical expert witnesses. Education and training ensure competence, accreditation provides individual or systems accountability and regulation affords a framework of standards for conducting professional practice.

5.2 Establishment of groups or teams of clinicians in the NHS to provide expert witnesses, as I have proposed in this report, will do a great deal to raise the quality of medical evidence for the courts. In particular, review of the work by peers and the opportunity provided by the groups for mentoring of those who are less experienced in the work will serve to raise standards. The groups will also form a focus for training activity, and should develop close links with local judges, barristers, solicitors and magistrates to allow all of those professions to undertake training and assist each other.

Proposal eleven: The knowledge and skills needed in all court settings should be taught as part of basic and continuing medical education. Relevant educational and standard-setting bodies should develop a competence-based syllabus for court skills. Within this development, priority should be given to medical expert work in child protection cases.

5.3 The clinical skills needed by doctors in the NHS should be underpinned, for those working for the courts, by a number of attributes.

Key attributes of a Medical Expert Witness

- In active clinical practice or retired within the last two years;
- Sees similar cases in day-to-day practice;
- A member of, and in good standing with, the appropriate Royal College or professional body;
- Up-to-date with continuing professional development;
- Mastery of the current evidence base that underpins practice;
- Knowledgeable of child protection issues;
- Able to understand the family context of the child.

5.4 It is important that medical expert witnesses should be able to distinguish the physical or mental signs which children may have that are consistent with abuse, and to differentiate these from other conditions such as metabolic and genetic diseases. An increasing evidence base is continually developing to support doctors in this field (see Annex D). It is also important that the expert evidence offered in court is open to peer review within the participating team, which will itself be bound by the court's rules on confidentiality. I welcome the review,[27] due to be reported this year, by the Royal College of Paediatrics and Child Health on the scientific quality of evidence given by medical expert witnesses in high-profile child abuse cases.

5.5 Medical expert witnesses also need additional knowledge and skills to work for the courts. A number of training programmes exist for medical expert witness work but there is no systematic training scheme in court skills at present. Doctors already practising in the NHS who are not currently acting as medical expert witnesses also need to be equipped to work for the courts. Some will acquire many of the necessary skills under the tutelage of experienced colleagues but many more will benefit from formal training as part of continuing professional development.

Knowledge and skills needed for family court work

Knowledge of:

- child protection legislation;
- the role and powers of the different courts, the standard and the burden of proof;
- the expert's role in key stages of the court process;
- how to interpret and influence solicitors' instructions;
- possible outcomes of the court's decision and the expert's potential contribution.

Skilled in:

- information analysis and presentation;
- oral and written communication of evidence, including report writing;
- responding to cross-examination;
- honest and balanced presentation of opinions on causation;
- high-quality forensic practice.

5.6 The Academy of Medical Royal Colleges co-ordinates the work of the medical Royal Colleges and, with the General Medical Council, has recently undertaken an initiative to establish what skills are needed by medical expert witnesses and when and where they should be taught. There is general agreement in the medical profession that training should begin at undergraduate level and should continue at postgraduate level, so that the necessary skills are learnt when they are most needed and more doctors are equipped to be a witness in court, whether as an expert witness or a witness of fact.

5.7 The generalisation of this philosophy is at the heart of *Modernising Medical Careers*[28] and, more recently, the *Curriculum for the Foundation Years in Postgraduate Education and Training*,[29] published jointly by the Academy of Medical Royal Colleges and UK Health Departments. The curriculum, with its delivery largely based in the workplace, sets out the educational content of the two-year foundation programme to be pursued by all newly qualified doctors in the UK from August 2005. The syllabus describing the skills, knowledge and attributes to be achieved by the modern doctor is founded on a core competence framework, elements of which are foundational to the skills and attributes for medical expert witness work.

Proposal twelve: Under the *Joint Memorandum between the Academy of Medical Royal Colleges and the Department of Health*, collaboration should be extended by the Academy to other relevant professional bodies – for example, the British Psychology Society and the Council for the Registration of Forensic Practitioners – to develop accreditation for teams of medical expert witnesses based on ISO 9000.

5.8 There is currently no national accreditation system for all experts but there is demand, particularly from judges and solicitors, for a means of securing information about a good supply and choice of skilled and 'tested' experts. Accreditation has the advantage that those who use medical expert witnesses can be assured of their competence independently. The question of accrediting expert witnesses features in both the Legal Services Commission consultation paper[30] and the report on *Sudden unexpected death in infancy*.[14] The former, and some of the responses to it, suggest that compulsory accreditation of individuals for family cases is not practicable in the short term because it might worsen the current problems of supply of medical expert witnesses. The report on *Sudden unexpected death in infancy* recommended accreditation of experts for their court work by the Royal Colleges or specialty associations.

5.9 A system of accreditation of individuals requires that those who need to be accredited as witnesses are checked and vetted and that a transparent system exists, with clear and published criteria, for inclusion on the list or removal from it. Any such system requiring vetting and monitoring would need to be resourced and kept up to date.

5.10 Magistrates, judges and the parties in public law Children Act proceedings will have an expectation, which should be met, that medical expert witnesses provided by NHS trusts in the future are quality assured. A system of accrediting individuals would inevitably focus demand for medical expert witnesses on those accredited, and would restrict the growth of supply by excluding doctors with less experience of acting as experts. So we need a system for accrediting teams. The question is what form a system of organisational accreditation should take: whether it should be aimed at the NHS teams providing the medical expert witness service, the consultant team leaders or clinical directors leading the teams, or the employing NHS organisations.

5.11 Any system for accrediting medical expert witnesses would need to involve the medical Royal Colleges and specialty associations in developing the standards and build on the experience of the Council for the Registration of Forensic Practitioners.[31] The Council, an independent, not-for-profit organisation funded by the Home Office to provide a register of experts for the criminal courts, has recently begun to accredit forensic paediatricians, in partnership with the Royal College of Paediatrics and Child Health. The aim is to assess an applicant's forensic medical skills. However, the process does not involve consideration of an individual's skills in giving evidence, and the House of Commons Science and Technology Select Committee in its report, *Forensic Science on Trial*,[15] was concerned that the process was not sufficiently rigorous.

5.12 Under the *Joint Memorandum between the Academy of Medical Royal Colleges and the Department of Health*,[32] the Postgraduate Medical Education and Training Board is leading a review of the quality assurance of postgraduate medical education, aspects of which will involve development of curricula and measures to improve training opportunities within the NHS. The review will include rationalising and harmonising current processes for visiting NHS trusts to assess and ensure the quality of medical education and training against national standards. It potentially provides a mechanism for quality assuring teams or managed local networks of teams providing expert medical evidence to the family courts.

5.13 The process of accrediting medical expert witnesses should be modelled on the system of checks of procedures (eg for formal training and supervision of the work of registrars), methods and standards of the team that is used in the quality checks for British Standards, rather than a check of past casework as currently undertaken for accreditation of individuals. It should work towards ISO 9001:2000 recognised by the

United Kingdom Accreditation Service,[33] as this is recognised internationally and has numerous benefits, including promotion of good working practices and a standard of organisation that comprises an integrated quality and performance management system with resource and management responsibility at its core.

Proposal thirteen: The General Medical Council should review its supplementary guidance, *Giving Expert Advice*, to widen its scope and bring it up to date in relation to recent developments and issues in this area.

5.14 In the context of its duty to promote good medical practice, the General Medical Council prescribes standards of conduct and probity through a range of guidance, much of which is applicable to medical expert witness work. Persistent or serious failure to meet the standards in the guidance puts a doctor's registration at risk. The core guidance, *Good Medical Practice*,[34] is currently under review by the Council and covers all aspects of professional conduct. The Council also issues supplementary guidance on a range of specific procedures. A standard exists on *Giving Expert Advice*, which largely focuses on contractual obligations in expert witness work. The General Medical Council should review this supplementary guidance to widen its scope and bring it more up to date with recent developments and issues.

Proposal fourteen: In the light of the consultation on *Good doctors, safer patients*, the Family Justice Council and relevant government departments should work with the General Medical Council to investigate all possible ways of dealing with complaints to the GMC about the expert evidence given by a doctor, so as to ensure that routes of appeal through the courts are used when they are appropriate.

5.15 In recent years, the General Medical Council has received an increasing number of complaints about evidence provided by doctors in legal proceedings. The great majority of those cases have concerned evidence in family proceedings and criminal cases. There are concerns within the medical profession about the risk of being reported to the General Medical Council simply as a result of having given evidence in a high-profile case. A few respondents to the survey mentioned this as the main reason that they were reluctant to act as an expert witness.

5.16 Some complainants have turned to the General Medical Council to challenge a report or evidence, resulting in the council being used to review decisions taken in a court, tribunal or other forum. Usually the complaints are made when the case has not been resolved in the complainant's favour and sometimes the complainant has not exhausted his or her opportunities to appeal to a higher court.

5.17 I appreciate that there are arguments in support of the public having a right to refer a complaint to the General Medical Council about a doctor even where it relates to the doctor's expert witness evidence. This is consistent with the position taken by the Attorney General in his submissions to the Court of Appeal in the recent case of the Meadow v General Medical Council, which concerned the High Court's decision that expert witnesses have immunity from disciplinary proceedings in the absence of a referral of a complaint by the judge hearing the case to the relevant statutory body. The judgment of the Court of Appeal is awaited.

5.18 It is important too, that a complaint to the General Medical Council should not be used as an alternative to appealing the decision taken by the court. The General Medical Council has held discussions with the Family Justice Council about changes to its procedures which could deal with some of doctors' concerns and I welcome this initiative. One possibility would be for the General Medical Council to approach the judge, chairman or magistrate to seek comments on the competence of the doctor as an expert witness at a very early stage, where a complaint has been made about his or her evidence. Another possible arrangement would be to require a potential complainant to exhaust his or her rights of appeal to the higher courts about the alleged unreliable medical evidence, before matters were taken forward by the General Medical Council. There may be other options to tackle the problem, involving legislative, administrative or procedural changes, and these should all be investigated. However, these would now need to be developed in the wider context of the awaited Court of Appeal judgment and the recommendations in my review *Good doctors, safer patients,*[24] which is subject to public consultation until November 2006. *Good doctors, safer patients* advocates an approach to medical regulation that promotes partnership and reaches into the local NHS. It is consistent with my proposals here in *Bearing Good Witness,* to locate the supply of NHS medical expert witnesses within NHS hospitals and primary care trusts and their governance and quality assurance arrangements.

Proposal fifteen: The checklist suggested below should be used by solicitors, magistrates and judges to establish the credentials of prospective medical expert witnesses.

5.19 The proposals I have set out for improving the supply of competent and quality-assured medical expert witnesses will need to be developed over time. Meanwhile, there is demand – from magistrates, judges, solicitors and barristers – for an early means of assessing the credentials of medical expert witnesses. One suggestion as to how this might be done involves creating a checklist of questions which lawyers, magistrates and judges might ask of prospective medical expert witnesses.

The checklist below, which could be used immediately, draws from recommendations in the Intercollegiate report on *Sudden unexpected death in infancy*.[14]

Questions for the magistracy and judiciary to establish the credentials of a medical expert witness

- Do you have a contract with the NHS?
- Do you work alone as medical expert witness or with a team?
- What is your area of practice?
- To what extent are you an expert in the subject on which you are being asked to testify?
- To what extent is your view in relation to the subject on which you are being asked to testify widely held by your colleagues and peers?
- Do you see similar cases to this one as part of your day-to-day work?
- When did you last see such a case in your own clinical practice?
- Are you a member of your Royal College/professional organisation?
- Are you up to date with continuing professional development?
- Have you had specific training to act as an expert witness? Was that in the last five years?
- Have you provided expert evidence for the court before? If so, when and where was that?
- Are you being helped or supervised by someone else in this work?

5.20 Recent high-profile cases have drawn attention to the need for medical experts to have a comprehensive knowledge of scientific research data and the skill to assess and interpret it. The interpretation of the results of multiple, possibly conflicting, clinical trials can be difficult for someone who is not an expert in statistics. Descriptive epidemiological studies citing the prevalence of particular conditions or abnormalities can be difficult to assess for their relevance to a more specific context than perhaps the one in which the studies were conducted. The sensitivity and specificity of tests and how to evaluate them based on published work can also be a complex matter for the medical expert drawing on experience of cases rather than scientific expertise.

Proposal sixteen: A National Knowledge Service to support the medical expert witness programme should be established.

5.21 There would be benefit to establishing a national body to provide advice and support to the medical expert witness programme. Such a body would not give advice on specific patients or cases, but rather on the status of current scientific knowledge in particular fields. It could provide a service to expert witnesses in the availability, validity and interpretation of scientific knowledge. It would also provide training to expert witnesses on the use of scientific and research information, identify fields of research where the scientific evidence is absent or unclear, and make recommendations for research that should be commissioned.

Annex A
Organisations and stakeholders seen

Stakeholders were seen in their individual roles and were not necessarily representing the views of their organisations.

American Academy of Pediatrics

Association of Directors of Social Services

Bindman and Partners Solicitors

Booth Hall Children's Hospital

British Psychology Society

Cardiff Law School

Oxford Centre for Family Law and Policy (OXFLAP)

Children and Family Court Advisory and Support Service

Council for the Registration of Forensic Practitioners

Expert Witness Institute

Family Justice Council

Family Law Bar Association

General Medical Council

Harrow Social Services

Law Society

Legal Services Commission

Magistrates Association

Marlborough Clinic

National Children's Homes

National Family and Parenting Institute

National Society for the Prevention of Cruelty to Children

Norfolk and Norwich University Hospital

North Bristol NHS Trust

Royal College of Paediatrics and Child Health

Royal College of Psychiatrists

St David's Hospital, Cardiff

Society of Expert Witnesses

Solicitor's Family Law Association

United Kingdom Register of Expert Witnesses

University Hospital of North Staffordshire

Government departments

Department for Constitutional Affairs

Department for Education and Skills

Department of Health

Home Office

Annex B
The experts role in the family courts

1. Children Act care and supervision proceedings normally arise from concern about a child or children. This may come to light through the involvement of social workers, health visitors, the general practitioner or other professionals working with family members. It could also result from a child being seen at an accident and emergency department in hospital. Information from the Department for Education and Skills suggests that many children who become the subject of care proceedings are already known to child welfare agencies. Often, their names are on the child protection register and earlier child protection plans will have been made for them.

2. It is for the local authority (and, in particular, its social services department) to make an application to the court about a child, which may result in the child being removed from its parents and taken into care. The application is made initially to the Family Proceedings Court. The local authority must provide enough information to allow the court to make a decision about the welfare of the child and how the case should be handled.

3. Before a local authority applies to the courts for a care order, it must satisfy itself that there is sufficient evidence that the harm threshold has been met. In many of the most serious cases, the local authority, sometimes at its own expense, will have obtained reports from both a treating clinician and an independent doctor.

Administration and reorganisation of the family justice system

4. The Family Proceedings Courts were, until recently, administered separately from Care Centres. From 1 April 2005, with the implementation of the Courts Act 2003, a unified court administration, covering both Family Proceedings Courts and Care Centres, came into effect. At local level, 42 Local Justice areas were created in England and Wales (38 in England).

5. A network of 'specialist family centres' is currently being piloted, which will become centres of excellence, with appropriate facilities and support staff within one building. These centres will combine the different levels of jurisdiction, will co-ordinate and oversee the hearing of public law family cases in the area, and will enable a cadre of specialist staff to be developed.

6. In London, where a pilot project for the new structure is in operation, overall legal management and accountability for the Care Centre and the 600 family panel magistrates rests with a family specialist justices' clerk. It is envisaged that each of the 'specialist family centres' will involve a senior full-time specialist family legal adviser.

Management of the case

7. The *Protocol for Judicial Case Management in Public Law Children Act Cases* (referred to in this report as 'the protocol'), sets out the steps to be followed in childcare proceedings and gives a guideline timetable for each stage. The court appoints a guardian for the child and fixes the date of the first hearing. The Child and Family Court Advisory and Support Service then allocates a guardian, who must appoint a solicitor for the child and notify the other parties to the case (the local authority and the parents) of the name of the guardian and solicitor. Within six days of the local authority's application, the Family Proceedings Court must decide what immediate steps are necessary. If the application for the child to be taken into care is being contested, the Family Proceedings Court may decide on a transfer to the County Court (Care Centre) if the proceedings are exceptionally grave, important or complex. The number of experts needed may be a factor in that consideration.

Need for evidence

8. If the facts are in dispute, the 'threshold' and 'disposal' stages of the case are likely to be heard separately and the case is likely to be transferred to a higher court. At the 'threshold' stage, the local authority brings evidence provided by local professionals (social workers, police, health staff and teachers) who were involved with the child in the ordinary course of their jobs. Such professionals may provide reports or evidence as 'witnesses of fact'. The Family Proceedings Court considers the management of the case, sets a date for the final hearing and, if appropriate, a pre-hearing review. Where a case is transferred to the Care Centre, the judge holds an allocation hearing at which he or she considers similar issues.

9. Where there is a dispute (whether at the 'threshold' or 'disposal' stages of the case), the parties may seek evidence from experts, including medical experts. If a child has suffered a fracture, for example, and it is disputed whether the injury was caused deliberately or accidentally, an expert medical report may be needed. Similarly, the parties might request an expert where there are allegations of sexual abuse or of neglect. At the 'disposal' stage of a case, experts may be required to assess the capacity of the parents to care for the child or to change behaviour, such as alcohol or substance misuse, which could be causing them to neglect the child's needs.

10. A lawyer, usually a solicitor for the party that wants expert evidence to be presented, approaches an expert, giving him or her information about the issues likely to arise and the questions to be answered. The lawyer has to provide information, including on the qualifications and expertise of the expert (often via a curriculum vitae) to the court. The lawyer must justify the need for an expert, say whether the expert can be jointly appointed by two or more of the parties to the case and, if so, how costs might be apportioned. There is a presumption that an opinion from a single expert in a specialty will suffice because, in the majority of cases, medical experts will agree about the evidence of harm to a child. However, any of the parties may contest this and apply to the court for the appointment of a separate expert.

Case management conference

11. A case management conference must take place regardless of whether the case is being heard in the Family Proceedings Court or in a Care Centre. At this hearing, the magistrate or judge considers documents filed by the local authority and by other parties, sets a timetable for the rest of the case and agrees (or otherwise) to the appointment of experts, including medical experts. The judge or magistrate must consider whether a report from an expert is necessary and may decide that the expert should be jointly instructed by all of the parties. Where the judge has agreed to the appointment of a single joint expert, he or she will also require that one of the lawyers (usually the solicitor for the child) co-ordinate the instructions. The letter of instruction should be approved by the judge or magistrate.

12. If there are several experts in a case, the instructions would cover the right of each expert to talk to the others (provided an accurate record is made of the discussion). The court can direct that experts should meet to narrow down the issues in the case and consider outstanding disagreements. Such a meeting is usually chaired by the child's solicitor, but where the medical issues are complex, it can be jointly chaired by an independent medical professional.

The hearing

13. The protocol states that the final hearing should take place by the 40th week following the application. Then the final determinations are made. A pre-hearing review is normally held to identify the issues and ensure that the final hearing will be effective. At this stage, it will also be decided whether any experts involved will need to give evidence in person at the final hearing. In at least 80% of Children Act care cases involving medical experts they do not make a court appearance. The issues are dealt with on the basis of their written report alone.

Delays

14. One of the purposes of the protocol is to attempt to reduce the time taken by Children Act care proceedings and avoid unnecessary delay. Monitoring data from the Department for Constitutional Affairs show that the involvement of experts can contribute to delay. In 2004, there were 5,195 delays in family proceedings, of which 611 (12%) were caused by the unavailability of experts or by late submission of their reports.

The role of the solicitors

15. The relationship between the solicitors (or other lawyers) and expert witnesses, including medical experts, in Children Act care proceedings is important in any consideration of the issues involved in the use of experts because:

- they have responsibility for identifying an appropriate expert;
- the responsibility for instructing the expert also falls to them.

16. The lawyers also have responsibility for negotiating and arranging payment of the expert's fee.

Identifying an expert

17. Some lawyers have more experience of identifying and instructing experts than others. Doubts about what expertise may be offered by each type of expert have led to production of some local guides which help legal professionals to understand what expertise disciplines such as child psychiatry or child psychology could contribute to a case.

18. Once a need has been identified, a lawyer's task in finding a suitable expert can be time consuming. Experts are often too busy to complete a case within a reasonable time span. Many lawyers approach experts they already know and this restricts the pool of doctors who are able to gain experience of being expert witnesses. It also does not encourage new entrants to this field of work. As experienced experts retire, there are few with the necessary skills to replace them. Some lawyers have called for a nation-wide directory of experts, to assist in identifying a suitable doctor for the needs of the courts and legal proceedings.

Preliminary inquiries

19. The protocol puts the instructing lawyer in the position of providing the expert with information about the issue to be decided by the court and questions on which an opinion is sought. The expert must be able to assess how much reading will be necessary, whether the child can be examined and interviews conducted, and whether

there are other experts in the case. Deadlines for producing reports and scheduling of court attendance must also be discussed. Sometimes the gap between the preliminary inquiries and formal instructions being given is unsatisfactory. As one expert in our survey put it:

> *"Currently, I can wait three months between an initial phone call and receiving instructions – then with only a few weeks to prepare the case and arrange court availability."*

Instructing the expert

20. The instructing lawyer must set out clearly the precise questions that the court wants the expert to address. There are sometimes problems with this part of the process, with examples of experienced experts having to guide the instructing lawyer rather than vice versa. Medical experts need precise and concise instructions:

    - to identify or diagnose the problem, if any;
    - to suggest what solutions or answers there may be;
    - to provide a recommendation and/or advice on what treatment is required.

21. To address the difficulties that can arise from failure to provide clear and relevant instructions, the National Family Justice Council has formulated some standard questions to be made available to lawyers instructing experts in family cases. These are set out below.

Suggested questions as a basis for instructions to medical experts

1. Describe the child's (current) health and development and:
   - describe the child's (current) functioning and/or difficulties, and the prognosis for these difficulties if they are not addressed; or
   - describe the child's presenting condition/injuries, if any.
2. Can you comment:
   - on the likely explanation and/or aetiology of the child's problems/difficulties/injuries; and
   - on the existence or likelihood of significant harm?
3. Can you describe and prioritise the child's needs, including the nature of future care-giving and treatment, in the light of the above, in the short and long term?
4. Can you advise as to the parents'/caregivers' ability to fulfil the child's identified needs?
5. What, if anything, would be required to assist the parents/primary caregivers to be able to do so; and, if assistance is needed, what is the prognosis and timescale for change?
6. Are other assessments needed?
7. What are the alternative possibilities for meeting the child's needs, and what are the implications of each?

Source: National Family Justice Council[35]

The content of the expert's report

22. The Protocol sets out what should be included in the expert's report and specifies that the report should be addressed to the court. It should include:

- details of the expert's qualifications and experience;
- a statement setting out the substance of all instructions (whether written or oral), summarising the facts that are material to the conclusions and opinions expressed in the report;
- details of any literature or other research material on which the expert has relied in giving an opinion;
- information on other people, including their qualifications, who carried out any test, examination or interview used for the report, and whether the test, examination or interview was carried out under the expert's supervision;
- information on whether there is a range of opinion on the question to be answered, in which case the report should summarise the range of opinion and give reasons for the opinion held by the expert;
- a summary of the expert's conclusions and opinions;
- a statement that the expert understands and has complied with his or her duty to the court, which is:
  - to provide an opinion that is independent of the party or parties instructing him or her;
  - to confine the opinion to matters material to the issues between the parties and in relation only to questions that are within his or her expertise (skill and experience);
  - to take into consideration all the material facts including any relevant factors arising from diverse cultural or religious contexts at the time the opinion is expressed;
  - to indicate whether the opinion is provisional (or qualified, as the case may be) and the reason for the qualification, identifying what further information is required, and to give an opinion without qualification.

Annex C
Numbers of experts used in public law family cases

(January–December 2004)*

Experts	Magistrates' courts (family proceedings courts)	County courts (care centres)	All courts
Adult psychiatrists and psychologists	1,458	1,153	2,611
Child psychiatrists and psychologists	436	464	900
Paediatricians	189	335	524
Physicians**	50	59	109
Residential assessors	105	107	212
Independent social workers	168	151	319
Other experts	230	403	633
Total	2,636	2,672	5,308

Source: Department for Constitutional Affairs

*These are cumulative. Figures are provisional because the Family Proceedings Courts did not cover all areas during this period and the start date when collection began differed between areas.
**Includes general practitioners and other specialists, eg ophthalmologists.

Annex D
The evidence base

1. It is important that medical expert witnesses should be able to distinguish the physical or mental signs which children may have that are consistent with abuse, and to differentiate these from other conditions such as metabolic and genetic diseases. An increasing evidence base is being developed continually and includes:

   - the National Institute for Health and Clinical Excellence (NICE) guideline on the identification of children who have been subject to physical, sexual or emotional abuse or who have a fabricated or induced illness.[36] Production of the guideline followed a Health Technology Assessment review of evidence and the use of guidelines for the recognition by doctors in accident and emergency departments of signs of abuse. When NICE has completed this work, medical expert witnesses in childcare cases will have a much firmer basis than at present for their opinions and conclusions on any individual case;

   - work being undertaken at the College of Medicine in Cardiff University to produce a series of systematic reviews of physical abuse in children, in collaboration with the NSPCC, and recently completed reviews of bruising, fractures, oral injuries and human bites. Its future work programme includes burns and scalds, non-accidental head injuries, retinal haemorrhages and abdominal injuries;[37]

   - the Royal College of Paediatrics and Child Health report *Fabricated or Induced illness by Carers*, which examines the evidence base, defines the condition, investigates and documents the different ways of managing it and contains guidance for paediatricians and other medical and social workers;[38]

   - *Evidence Based Guideline for the Management of CFS/ME (Chronic Fatigue Syndrome/Myalgic Encephalopathy) in Children and Young People* – December 2004;[39]

   - Unexpected Fracture in Infancy – Old Suspects, New Suspects (under preparation for the *Archives of Diseases in Childhood*).

2. There are, however, a number of areas in which the evidence base is undeveloped or undocumented, especially in child psychiatry. There is a need to help all NHS staff to identify signs of abuse. The Victoria Climbié[40] case highlighted the need for more work on three themes. The Department of Health and Department for Education and Skills have a joint research initiative worth £2.25 million over four years from

2005 to investigate these themes and provide an evidence base to safeguard and promote the welfare of children.[41] The themes are:

- recognition of neglect or emotional abuse (especially focusing on neglect and emotional abuse, which have received less attention than physical and sexual abuse);
- evaluation of interventions in cases of neglect or emotional abuse (supportive and rehabilitative efforts to enable children to achieve their optimal development, often in the child's own home or a substitute family setting);
- new arrangements to promote inter-agency and multi-disciplinary working (collaboration between statutory agencies/voluntary organisations and impact of new structural arrangements to promote it).

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