



GRESHAM COLLEGE
Founded 1597

Expert Witnesses: A Zero-Sum Game? Transcript

Date: Wednesday, 12 April 2017 - 6:00PM

Location: Barnard's Inn Hall

12 April 2017

Expert Witnesses: a Zero-Sum Game?

Professor Jo Delahunty QC

Whether it is ordering a passionately vegan mother to vaccinate her child against her parental wish[1], or deciding if a baby should receive experimental medical treatment without sufficient proof it will improve his quality of life or save it[2]: medical evidence is crucial to the determination of many cases in the family courts.

- What of a parent of a seriously ill child with a malignant brain tumour where urgent radiography was advocated by the medical treating team but the mother refused consent, genuinely believing that the medical treatment proposed for her son was not necessary and advocated alternative holistic treatment which the experts opined was either experimental or unsuitable?[3].
- What of the parents who proton beam therapy could save their child without the side effects of conventional radiotherapy but was unavailable in the UK and the parents took their child out of hospital, out of the country and away from his UK medical team? The treating hospital feared that without their treatment the child's condition could seriously decline. Should the family be tracked down, the parents arrested, the child removed and placed in the nearest hospital, thence returned to England to resume the treatment plan advocated by the doctors, against the wishes of the parents ? Or should the parents be allowed to continue their journey and secure the treatment for their son that they believe will cure him[4]?
- Who is to decide between a health trust and a parent when doctors wish to withhold medical treatment and allow a child to die[5] but a parent wishes to prolong the life of their child albeit one with no apparent quality of life, no real prospect of improvement and, unless artificially prolonged through invasive medical treatment, death in days, weeks or even months is a real one? [6].
 - Such applications as these often come before the court as an emergency. Medical evidence is heard alongside the parent's rationale for resisting medical advice. Applications may be made under the court's inherent jurisdiction, wardship, or under s 31 of the Children Act 1989 (care proceedings). Whatever the jurisdiction, the focus is on the child and the task of the judge hearing these cases is immense complex.
 - When does the court intervene? How does it decide whether it should intervene and what it should do if it does?
- The short answer is that the family court will make a decision based on the best interests of the child, making the child's welfare its paramount consideration[7], balancing the wishes, opinions and views of the parent alongside medical advice. Whilst the court must give 'very great weight' to the parental wishes, they are 'subordinate to welfare'[8].
- To decide cases where private parental responsibility and choice becomes a court issue because of concerns of medical and health care professionals, the court applies a 'Best Interest Test' which Jackson J set it out with characteristic clarity in one such case [9] . I summarise it below. As you read it you will appreciate the weight of responsibility the court bears. Judges may hold the balance between life and death in their hands:

When a dispute arises between the treating doctors and the parents, and one, or both parties have asked the court to make a decision, it is the role and duty of the court to do so and to exercise its own independent and objective judgment.

The right and power of the court to do so only arises because the patient, a child, lacks the capacity to make a decision for himself.

The court does not decide what decision it might make for itself if it was, hypothetically, in the situation of the patient; nor for a child of its own if in that situation; nor whether the respective decisions of the doctors on the one hand or the parents on the other are reasonable decisions.

The matter must be decided by the application of an objective approach or test.

That test is the best interests of the patient. Best interests are used in the widest sense and include every kind of consideration capable of impacting on the decision. These include, non-exhaustively, medical, emotional,

sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations.

It is impossible to weigh such considerations mathematically, but the court must do the best it can to balance all the conflicting considerations in a particular case and see where the final balance of the best interests lies.

Considerable weight (Lord Donaldson of Lynton MR[10] referred to "a very strong presumption") must be attached to the prolongation of life because the individual human instinct and desire to survive is strong and must be presumed to be strong in the patient. But it is not absolute, nor necessarily decisive, and may be outweighed if the pleasures and the quality of life are sufficiently small and the pain and suffering or other burdens of living are sufficiently great.

All these cases are very fact specific, i.e. they depend entirely on the facts of the individual case.

The views and opinions of both the doctors and the parents must be carefully considered. But it is important to stress that the reference is to the views and opinions of the parents. Their own wishes, however understandable in human terms, are wholly irrelevant to consideration of the objective best interests of the child save to the extent in any given case that they may illuminate the quality and value to the child of the child/parent relationship.

- In the balancing act identified above the views of the parents are weighed in the balance with the opinions of the treating medics and such experts as are instructed: but what these cases do not suggest is that there is anything other than a genuine divergent view as to what is in the child's best interest. Parents may be in dispute with one another about what medical treatment their child should receive, or there may be a dispute between the parents and the treating medical team but there is an altogether different class of cases where the parent and the state are involved because of suspected child abuse: these become care proceedings initiated under s 31 of the Children Act 1989

In my last lecture Crime and Punishment 2 'When Legal Worlds Collide: Guilty until Proven Innocent' <https://www.gresham.ac.uk/lectures-and-events/guilty-until-proven-innocent>, using the case of *Al Alas and Wray* [2012] EWHC 865 (Fam)[11] <http://www.bailii.org/ew/cases/EWHC/Fam/2012/865.html>, I sought to illustrate the importance that experts can make to the outcome of a case by focusing on the example of one family and on one dead child when the parents were suspected of shaking their baby but the cause of death was unmasked in the family court as benign.

Al Alas and Wray involved allegation of a shaken baby and in such cases there is a small pool of available experts who are willing to be instructed; especially for the parent. The science on which expert opinions depend is complex and sometimes contentious [12]. The acceptance or rejection of those opinions by the court has a pivotal effect on the outcome for the family at the heart of the case.

Medicine plays a crucial role in informing judicial decisions. The court tries to do the best it can on the science known to the experts it entrusts to help it make the best decision for the welfare of the child; but science has its limitations and the judge decides the case, not the experts.

I make it plain that in talking about the issue for the court family to resolve in this lecture I am focusing on those cases involving the local authority and the family where suspicion have arisen that a child has been abused and care proceedings have been commenced.

Tonight, focusing on care cases where physical child abuse is suspected and using Al Alas in which I acted as a case example, I will seek to explain

Why the use of experts in family cases is so different to the approach towards them in crime and civil law

What the duties of experts are in family cases

Why treating medics may be experts in their clinical practice but they are to avoided as 'experts' in care cases

Why science has to be placed in the context of all the evidence known to the family court

The burden on the legal aid lawyers representing the alleged abusers in these case

Why science and the courts don't have all the answers : and why both can get it wrong

Warning: the cases discussed can be distressing: they involve very serious, sometimes fatal, injuries to a child

and the discussion about the injuries they have sustained will sound dispassionate: but no professional or parent who deals with these cases can forget that a child has suffered pain that everyone would wish it had been spared in its short life

-

Why the instruction of experts is so different in family care cases versus crime

-

If a child has died in suspicious circumstances any surviving children at risk from those implicated in the harm to the dead child are likely to be removed temporarily from the home until the court can determine if it is safe for them to return, even if they have not themselves been harmed to date.

As I have said before: the family court is unique in looking to the events of the past only to determine safe arrangements for the child in the future.

-

From previous lectures you will know that in order for the state to justify its interference in the right to family life the local authority has to prove that 'threshold' is crossed. That means it has to prove that the child has, or is at risk of suffering serious avoidable harm at the hands of his or her parent or members of its household[13]. It is for the local authority to prove their case on a balance of probabilities (not beyond all reasonable doubt as in the criminal court)[14]

-

When there is no agreement on to how a child came to die or sustain serious injuries the court will be asked to consider if experts can help it make its decision: to divine, from the analysis of the child's body and medical records, what happened to that child in the build up to the death or moment of injury?

There will be different experts instructed depending on the nature of the injuries and whether the child has survived or not.

Think of the stark difference between a paediatrician examining a child's body in life and a paediatric pathologist examining the child's body after death.

In the former case the paediatrician will be looking at what can be gleaned from the examination of the child's body without inflicting damage on it: brain imagery, retinal imagery and x rays will take the place of opening up the body and extracting physical samples of the brain, bones and eyes.

In criminal cases, the prosecution will have a range of experts already instructed in the case of a child's death: they would have become involved prior to the post mortem.

The paediatric forensic pathologist will have been instructed by the police to conduct or observe the post mortem and he or she will already have a range of disciplines in mind to whom he expects to send bodily samples to for examination: in cases where violence through shaking is suspected this may include, as a minimum: neuropathology, ophthalmology, osteopathology, neuro-radiology.

By the time the investigation has led to charge, the prosecution will have a range of experts already involved in the case. They may instruct others on the advice of existing experts as evidence emerges. The defence do not have to adopt the Crown's experts already in place nor do they have to jointly instruct any who come later with the Crown.

The defence will be entitled to approach their own experts to rebut the case made against their client. Who they approach will be a matter for them. They don't have to tell the Crown or court who they have approached. They can see a draft report from their expert and may discuss it and suggest changes: whether the expert does so or not is up to the expert.

The point is that this selection of, and dialogue with, the expert is progressing in private within the defence team. It will be up to the defence if they serve the report they have obtained. They might seek a second opinion if the first isn't favourable. The expert will be pre-eminent in his or her field and may be UK based or from abroad. When the trial is underway experts may attend court and can give assistance to counsel as points of scientific and medical importance arise e.g.) advising on line and points of cross examination.

The relative freedom of our colleagues at the criminal bar to select, fund and liaise with the experts they deploy in the criminal jurisdiction is to be contrasted and compared to the protocols and funding restrictions which control the family justice system.

In care cases we have transparency because the court is concerned to make the best decision based on the welfare of the child. This transcends the right of the parent, as alleged abuser, to seek and withhold confidential

material that might affect the court's deliberations. If an expert report is obtained (permission having been granted) then it is disclosed to all the parties and the judge whoever it is to the benefit to: the local authority and parent's counsel deal with any dispute between the experts, or the experts and the factual evidence, openly by cross examination.

This underscores the main difference between care and crime where expert evidence is deployed by both sides. In a criminal trial the jury hear all the evidence and determine matters of fact. If they are confronted with two equally eminent experts who expound different conclusions as to cause of a baby's death: how are the jury to decide which expert is 'right'. They have to be satisfied of guilt beyond all reasonable doubt. The expert evidence they hear will be complex and the jury members may never have encountered it or anything as serious before. How can they be sure of guilt when an expert for the defence has planted a seed of doubt in their minds? Speaking from a position of eminence in their field? This is the 'zero: sum' scenario I alluded to in this lecture title. The two experts may cancel each other out leaving the jury unsure who to prefer. Doubt is to be resolved in favour of the accused. There is no parallel situation in a family care case where the expert evidence is effectively 'pooled' in order to give the judge the best evidence from which to form his/her overall conclusion as to what happened to the child. Moreover, the judge decides matters of fact as well as law so s/he will consider the expert evidence in the context of the entire factual matrix of the case: in care cases: the expert advises but the judge decides.

Under what constraints are experts chosen and instructed: how do their duties affect their role in the court?

In a family care case; those acting for the respondents come into a case when the suspicions of the treating medics have already led to the police and social services being notified.

In family public law, unlike in any other jurisdiction, no expert can be instructed without the court's permission. That means the court must be presented with a Part 25 written application, served on all parties, which sets out what expert discipline is required, what expert within that discipline has been considered, the expert's CV and payment rates, a timescale to report and the questions the expert is to be asked to address. The application is not just a formality. The court's permission is required, parties may object if there is already an expert (LA /Police) in place and, above all, the court must be satisfied that the involvement of the additional expert is 'necessary'[15]. The need for the expert can't simply be marginal to outcome, it has to be fundamental to the court's consideration of the issue at stake.

In summary the key points here are as follows:

No party can approach an expert and seek to instruct him or her without the permission of the court

That requires a formal application on notice to all the parties

Other parties may object: even if they don't they know who you are approaching and why

The court will want this to be a 'joint instruction' : that means that the letter of instruction will need to be openly discussed with the local authority and other parties and agreed

A date will be set for the report to be served

When served it will be served on all parties, in its final form, simultaneously

There will not be any discussion with any solicitor that is not recorded and disclosed to all parties

The report gets served whether or not it is favourable to the parent or local authority. Unfavourable reports cannot be suppressed,

The expert may be invited to participate in a recorded expert debate but the expert will not be permitted to have a dialogue with any one legal team: let alone discuss the case with any barristers instructed

The experts duty is to the court to give a balanced and informed decision: it does not have any duty to the person or party instructing him or her (Part 25.3 (2))

What is an expert?

For the answer we look to Part 25 of the Family Procedure Rules 2010

—
The expert has been active in the area of work or practice, (as a practitioner or an academic who is subject to peer appraisal), has sufficient experience of the issues relevant to the case, and is familiar with the breadth of current practice or opinion.

The expert has working knowledge of the social, developmental, cultural norms and accepted legal principles applicable to the case presented at initial enquiry, and has the cultural competence skills to deal with the circumstances of the case.

The expert is up-to-date with Continuing Professional Development appropriate to their discipline and expertise, and is in continued engagement with accepted supervisory mechanisms relevant to their practice.

If the expert's current professional practice is regulated by a UK statutory body they are in possession of a current license to practice or equivalent and carries professional indemnity insurance.

—
If the expert's current professional practice is outside the UK they can demonstrate that they are compliant with the FJC 'Guidelines for the instruction of medical experts from overseas in family cases'.¹

The expert has undertaken appropriate training, updating or quality assurance activity – including actively seeking feedback from cases in which they have provided evidence- relevant to the role of expert in the family courts in England and Wales within the last year.

- The expert has a working knowledge of, and complies with, the requirements of Practice Directions relevant to providing reports for and giving evidence to the family courts in England and Wales. *This includes compliance with the requirement to identify where their opinion on the instant case lies in relation to other accepted mainstream views and the overall spectrum of opinion in the UK.*

Note Part 25 r 3: It is the duty of experts to help the court on matters within their expertise. *An expert in family proceedings has an overriding duty to the court that takes precedence over any obligation to the person from whom the expert has received instructions or by whom the expert is paid.* [17]

What does the court look at to determine 'necessity'?

Answer; we look to rule 25 (5) and (7).

When deciding whether to give permission as mentioned in rule 25.4(1) in proceedings other than children proceedings, the court is to have regard in particular to –

- (a) The issues to which the expert evidence would relate;*
- (b) The questions which the court would require the expert to answer;*
- (c) The impact which giving permission would be likely to have on the timetable, duration and conduct of the proceedings;*
- (d) Any failure to comply with rule 25.6 or any direction of the court about expert evidence; and*
- (e) The cost of the expert evidence.*

Duties of an expert (Part 25 r 4.1)

An expert shall have regard to the following, among other, duties –

- (a) To assist the court in accordance with the overriding duty;*
 - (aa) in children proceedings, to comply with the Standards for Expert Witnesses in Children Proceedings in the Family Court which are set out in the Annex to this Practice Direction;*
- (b) To provide advice to the court that conforms to the best practice of the expert's profession;*
- (c) to answer the questions about which the expert is required to give an opinion (in children proceedings, those questions will be set out in the order of the court giving permission for an expert to be instructed, a child to be*

examined or otherwise assessed or expert evidence to be put before the court);

(d) To provide an opinion that is independent of the party or parties instructing the expert;

(e) To confine the opinion to matters material to the issues in the case and in relation only to the questions that are within the expert's expertise (skill and experience);

NOTE: it is here that controversy has arisen in relation to the evidence of some experts, particularly in paediatric neuropathology[18].

(f) where a question has been put which falls outside the expert's expertise, to state this at the earliest opportunity and to volunteer an opinion as to whether another expert is required to bring expertise not possessed by those already involved or, in the rare case, as to whether a second opinion is required on a key issue and, if possible, what questions should be asked of the second expert;

(g) in expressing an opinion, to take into consideration all of the material facts including any relevant factors arising from ethnic, cultural, religious or linguistic contexts at the time the opinion is expressed;

(h) To inform those instructing the expert without delay of any change in the opinion and of the reason for the change.

Contents of the experts report (Part 25 (9.1))

Inter alia: in expressing an opinion to the court –

- take into consideration all of the material facts including any relevant factors arising from ethnic, cultural, religious or linguistic contexts at the time the opinion is expressed, identifying the facts, literature and any other material, including research material, that the expert has relied upon in forming an opinion;*
- describe the expert's own professional risk assessment process and process of differential diagnosis, highlighting factual assumptions, deductions from the factual assumptions, and any unusual, contradictory or inconsistent features of the case;*
- indicate whether any proposition in the report is an hypothesis (in particular a controversial hypothesis), or an opinion deduced in accordance with peer-reviewed and tested technique, research and experience accepted as a consensus in the scientific community;*

Where there is a range of opinion on any question to be answered by the expert

- summarise the range of opinion;*
- identify and explain, within the range of opinions, any 'unknown cause', whether arising from the facts of the case (for example, because there is too little information to form a scientific opinion) or from limited experience or lack of research, peer review or support in the relevant field of expertise;*
- give reasons for any opinion expressed: the use of a balance sheet approach to the factors that support or undermine an opinion can be of great assistance to the court;*

As the Court of Appeal urged in R v Cannings [2004] EWCA Crim 1; [2004] 1 WLR 2607, The courts should approach the evaluation of medical expert evidence and always be on guard against the over-dogmatic expert, the expert whose reputation or amour propre is at stake, or the expert who has developed a scientific prejudice.

Before obtaining permission to instruct an overseas medical expert in family proceedings, a party needs to satisfy the court that the expert has something genuinely exceptional to offer in terms of his/her expertise and must also explain in writing.[19].

Experts: UK based or a wider pool?

The Court of Appeal in Re M (A Child) (2012) AC 9601496 (declaration: a case in which I appeared) confirmed that the FJC guidelines also applied to the instruction of fresh expert evidence: the court needed to be satisfied of various issues such as:

why a UK expert had not been used.

what efforts had been made to identify UK experts and

why such experts had been rejected/ were not pursued and

what the financial implications were of instructing an overseas expert

-
Having gone through this you may now see why we, in the family care courts, are so envious of our criminal practitioners.

Transparency is the key. No expert can advise behind closed doors. No papers can be shared without the court's permission as they are confidential to the court. No expert can be approached to give an opinion and then 'ditched' if it is unhelpful.

Why treating medics may be experts in their clinical practice but are to be avoided as 'experts' in the cases in which they have been medically involved

-
In cases where a local authority is propelled into urgent action by allegations of inflicted injury and death, it is inevitable that the evidence which gives rise to that allegation will emanate, at least in part, from those medical professionals who treated the child.

A local authority application will be drafted specifically to support the Local Authority's (LA) application for an interim care order (ICO) and interim removal of any relevant surviving child/ren of the family. Under the template introduced by The President as part of his law reforms the application and supporting evidence should reveal all relevant evidence both in favour of and against allegations of abuse: this is vital when removal of a child is sought by the LA based on the evidence they submit to the court. These rules were not in operation in 2012/3. This may explain why, in *Al Alas v Wray* (declaration: I appeared on behalf of the mother Chana Al Alas), the vital post mortem report of Dr Irene Scheimberg (Pathologist instructed by the Coroner who actually conducted the post mortem) indicating the possible presence of rickets and the need for Vitamin D testing of Chana Al Alas (although in existence) was not disclosed by the LA to the family lawyers at this stage. We only received was the evidence of Dr Mark Peters' opinion (treating paediatric intensivist at GOSH where the child died) and Dr Cary's summary of the post mortem findings (forensic police pathologist instructed by the police who observed the PM conducted by Dr Scheimberg): both Dr Cary and Dr Peter's opinions being strongly supportive of Non Accidental Head Injury (NAHI).

Treating medics form opinions in less than ideal circumstances because timely medical analysis and intervention is the clinical imperative. The hospital work place is not immune from suspicions being aired between stressed colleagues as soon as Non Accidental Injury (NAI) is raised as a possible cause. Corridor discussions inevitably take place (unrecorded) where opinions are formed as evidence is emerging and facts are unclear.

The Reality: Treating medical professionals in such situations will have formed a clear view or opinion and if their evidence is put before a Court by a LA it is likely to be because they have decided that injuries have been inflicted.

-
Historically the practice has been not to commission expert reports from treating clinicians.

-
In the case of *Re B (Sexual Abuse: Expert's Report)* [2000] EWCA CIV 516, Thorpe LJ said:

"It ought to be elementary for any professional working in the family justice system that the role of the expert to treat is not to be muddled with the role of the expert to report."

-
However, there is no embargo on such evidence being obtained if appropriate.

As Thorpe LJ observed in *O-M, GM (and KM) v The Local Authority, LO and EM* [2009] EWCA Civ 1405,

"Clinical involvement did not, of itself, affect a doctor's capacity to act as an expert witness; a blanket approach that precluded treating clinicians from becoming jointly instructed witnesses in respect of children they had treated would risk depriving the court of expertise and excellence"

But Thorpe LJ drew a clear distinction in respect of medics who had firm views as a result of their treatment of the child about the very issue the court had to determine:

"Medical evidence was to be looked at in terms of the court proceedings: there was a clear distinction to be drawn between a medical decision as to what was clinically required for a child's treatment and a forensic decision about what was necessary to ensure a proper determination of an issue"

—

[Please also see the excellent judgment of Baker J in *Devon County Council v EB & Ors \(Minors\)* \[2013\] EWHC 968 \(FAM\)\[20\] para 137-139 in the case of where he set out why, after the court's extensive inquiry into the circumstances of the children's injuries he had come to recount the treating clinicians belief that the injuries were inflicted. He had no complaint of them. He was simply identifying, realistically and compassionately the stresses and exigencies under which treating clinician's operate when a child comes to their attention and the suspicion of abuse is raised by his or her medical presentation.](#)

The Court's enquiry in Al Alas into causation of injuries and death was in effect a consideration of whether or not the opinions clinicians formed when treating Jayden were valid. This was relevant to the adequacy of the treatment, which was in turn relevant to the issue of causation of encephalopathy. The Court had the benefit of all of the evidence, a huge range of expert opinion, and could take an unfettered view in relation to the treatment given by UCL and GOSH.

Experts instructed within family proceedings have an overriding duty to the court that takes precedence over any obligation to the person from whom the expert has received instructions or by whom the expert is paid. They receive the reports of the treating medics and the medical records to form an independent view as to:

What they see

What their answers are to the questions agreed they should answer

What evidence and research they rely upon to do so

We operate on the basis that what needs to be known of an expert's opinion is written down, disclosed in time to be considered so that there is transparency of the opinion and analysis of the research and facts that inform it before the witness gives evidence. It is that 'advance notice' and transparency which is meant to allow the advocates to challenge the experts evidence in the witness box.

The Family High Court in Al Alas had the assistance of many eminent experts called by the Crown (and then the Local Authority) and the Defence (the parents as respondents in the care case). We heard from 14 experts from within and outside the UK. To any specialist advocate involved in TRIAD cases in either the family or criminal division cases some of the names instructed are a familiar roll call of the hawks and doves of the scientific world: operating in an expert community where science and opinions upon it can be contentious as well as complicated. Those of us who act regularly in these cases will have an expert's address book of what experts to use and avoid in certain cases when we are acting for parents but note that, ultimately, the choice of the expert has to be agreed by the parties, or, in default of agreement, approved by the judge.

The conclusions the court in Al Alas came to after hearing all the evidence, medical, community, parental and the experts were stark. The care afforded to Jayden by UCL (the first receiving hospital) was 'sub optimal' and GOSH (the hospital where the child was transferred and died) 'missed' radiologically evident signs of rickets. Both omissions were critical when it came to determining whether the child had died as a result of a shake or not.

As Mrs Justice Theis observed

'I am very aware that this court has had the opportunity, as did the CCC, to consider the events of the 22.7.09 – 25.7.09 in exhaustive detail, with the benefit of expert evidence over a number of weeks. I am acutely aware that the clinicians operating on the ground, dealing with such urgent situations as occurred in this case, simply don't have that luxury.'

I very much doubt that, but for the instructions already made within the criminal case in Al Alas that we, the care family team, would have been able to secure court permission for instruction of, or LSC approval of funding for, some / all of the experts afresh (particularly the overseas experts who proved to be critical to its outcome. The use of a biomechanical expert in care cases has not found favour in subsequent cases.

The UK has a self-limiting pool of experts willing to give evidence in family cases. The criminal bar has greater choice and flexibility over disciplines, jurisdiction and numbers. They are to be envied that freedom.

We must protect our right to use experts. We must explore ways in which we can make greater use of their expertise, while still maintaining the transparency upon which the family justice trial system depends.

Why science has to be placed in the context of all the evidence known about the family

More and more of these cases involving death or serious injury are being explored in detail at court as science evolves in its understanding of how the body works.

The court can only make the decision it is asked to make on the basis of the best evidence available to it at the time.

Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence.

In [A County Council v KD & L \[2005\] EWHC 144 Fam.](#) At paragraphs 39 to 44, Mr. Justice Charles observed:

"It is important to remember that

(1) The roles of the court and the expert are distinct and

(2) It is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. The judge

must always remember that he or she is the person who makes the final decision."

Later in the same judgment, Mr. Justice Charles added (paragraph 49)

"In a case where the medical evidence is to the effect that the likely cause is non-accidental and thus human agency, a court can reach a finding on the totality of the evidence either

(a) that on the balance of probability an injury has a natural cause, or is not a non-accidental injury, or

(b) that a local authority has not established the existence of the threshold to the civil standard of proof ...

The other side of the coin is that in a case where the medical evidence is that there is nothing diagnostic of a non-accidental injury or human agency and the clinical observations of the child, although consistent with non-accidental injury or human agency, are the type asserted is more usually associated with accidental injury or infection, a court can reach a finding on the totality of the evidence that, on the balance of probability there has been a non-accidental injury or human agency as asserted and the threshold is established."

As Mr. Justice Ryder observed in [A County Council v A Mother and others \[2005\] EWHC Fam. 31:](#)

"A factual decision must be based on all available materials, i.e. be judged in context and not just upon medical or scientific materials, no matter how cogent they may in isolation seem to be".

The evidence of the parents is critical. The relevance of information from neighbors around the time of the alleged assault can be critical: did they hear a row, raised voices, scream, thud, silence? What does the carer say on the 999 call as that is often the first account given of a child's collapse? How do they sound on the recording? Can the child be heard? Are the accounts they give as to the build up to the collapse and what they did consistent over time? Does it fit with the medical evidence? Is there a history of violence or loss of control by any carer? Has there been previous concerns about neglect, lack of capacity to cope? Etc. etc. in short, there is much evidence beyond the medical picture to consider.

The court's duty was beautifully expressed by Baker J in the case of [Devon County Council v EB & Ors \(Minors\) \[2013\] EWHC 968 \(FAM\)\[21\]](#) :

The judge emphasized the need for the court to survey a "wider canvas" than that of the medical information in isolation and stressed that in cases of suspected physical abuse the court must "follow the evidence and pursue the

enquiry in whatever detail and for however long is necessary to arrive at the truth."

The burden on the legal aid lawyers representing the alleged abusers

What a specialist child protection barrister does in an alleged non accidental injury case: without expert assistance, an illustrative list.

- *We have to get to grips with the medical records which can run into thousands of pages, handwritten, repetitive, nurses notes, blood charts, med charts, and oxygen stats. Medical Records are the critical material because they are the building blocks of counsels understanding of the case their client faces and the options open to the barrister to forensically explore other potential causes of death or injury other than inflicted NAI:*
- *We scrutinise*
-
- *The Red Book (the early years home kept health record)*
- *Health Visitor records*
- *Midwife records*
- *Antenatal care records*
- *Community care records*
- *GP record*
- *Hospital records*
- *Nursing notes*
- *Drugs charts*
- *Temperature charts*
- *Feeding charts*
- *Copies of any imaging: scans/ MRI's/ x rays : not just opinions upon them*
- *These are just for the injured child. In addition we will look at a parent / sibling's health records to see if any trends, anomalies, genetic issues have been overlooked*
-
- *We draw up: a medical chronology*
- *Times child seen pre critical admission; whether clothed/ handled etc. for signs of pain, parental interaction*
- *Observations of the child upon critical hospital admission*
- *Tests done and by whom upon admission*
- *Medication given*
- *Treatment plan*
- *'Oddities' : things to follow up as you get expert's reports in*

There is no alternative but to dive into and, digest and decode the medial records: even though we aren't medics:

- *we have to understand them (or try to) to extract key entries ,*
- *we get to know where key pages are,*
- *we get to understand how the child's condition developed*
- *we get to see what happened prior to each critical investigative stage (e.g.: raised ICP (Intracranial Pressure) before a retinal examination?)*
- *we get to see how their treatment plans impacted upon their condition and its physical manifestations (e.g. an unmanaged CO2 level and no treatment plan : see Theis J criticisms of UCL in AI Alas as a result)*
- *we have to test the expert's summary and understanding of the medical records against the reality of the notes (have they operated from a police summary or have they read all the relevant notes themselves: see the consequences of Dr Bonshek's omission to do the latter in AI Alas)*
- *The medical chronology enables you to check the facts of YOUR case against the generalities of the research material and case studies relied upon by the experts*
- *AND, most importantly*
- *The chronology becomes a critical cross examination tool. It forces you to dive into the unwieldy and intimidating mass of handwritten , jargon infested , medical notes written in God knows how many different hands and scripts and translate them into a record written by you, cross referenced to the notes by you, and understood by you.*
- *It better enables you to ask intelligent, source based, questions of medics and experts whose knowledge on their specialist subject far exceeds your own.*
- *It enables you to respond, when you are on your feet, cross examining an expert, to the answers they give: we do NOT have an expert sitting beside us to whisper sotto voce what the killer rebuttal point/question is. Care practitioners have to think on our feet when challenging an expert who has reached an adverse conclusion to our client's case.*
-
- *The Research*
-
- *As a matter of good practice any expert instructed should volunteer the research that is relevant to their opinion. Its omission, or selective provision, is not a good sign and should not be accepted. You need to have access to the research papers that they rely upon to support their opinion AND those papers which might go to contradict it.*
- *The care court will be looking at differential diagnosis to inflicted abuse and we are entitled to look to the experts instructed to alert us to contrary opinions and emerging thoughts that they have relied upon. When research is out of date or lacking: they should say so. Not many do*

- *So: we, as specialist child protection barristers*
- *–*
- *demand it,*
- *read it,*
- *explore beyond it,*
- *we look out for our own research*
- *have to be prepared to challenge the expert's application of it TO THE FACTS OF THIS CASE*
- *–*
- *We Respect the expert who has clearly considered with diligence the child's medical records, the differential diagnosis and explains the rationale for rejecting/accepting one as opposed to another.*
- *We Respect the expert who is willing to acknowledge that science is evolving and sometimes the right answer is 'I don't know'. That's not a sign of weakness: it's a sign of professional strength.*
- *We have to remember that a competent expert's written report is likely to represent only the tip of their deliberations. We explore that in evidence. We ask about areas that troubled them, factors which, while they might have ultimately have come down in favour of non-accidental injury, might militate against it.*
- *An over dogmatic expert is a dangerous and weak witness. If that's their approach: expose and exploit it.*
- *–*
- *And note: even the most respected and eminent of experts can trip themselves up*
- *–*
- *In Al Alas: Dr Bonshek's (ophthalmologist) opinion was that the Retinal Haemorrhages were proof positive of NAHI through shaking. He had ostensibly considered raised intra cranial pressure (ICP) as a potential cause but discounted it: but he hadn't read the full medical notes, only the summary from the police and those records from GOSH. He had known the child had been admitted to UCL but hadn't asked to see and thus hadn't read their records. When read they revealed that the child had sustained a very sharp increase in ICP BEFORE the ophthalmic examination at GOSH. He had also failed to consider the raised CO2 levels at UCL which he accepted could have had an effect on vaso constriction and hence the formation of RH. The medical records were the key to cross examination.*
- *The point is that advocates have GOT to be prepared to get down and dirty with the medical records and research.*
- *–*
- *Both sets of material are complex, difficult to digest and are intimidating.*
- *But, since we don't allow experts to cross examine one another in the court room, and we don't have the luxury that our criminal counsel have of an expert sitting behind them to advise on questions to ask as their counter- part expert is in the witness box, it falls to the family advocate to perform that task using the experts tools of the trade to the best of that advocates ability.*

Al Alas: The Mammoth Task: Cross Examining 40 Clinicians and 14 Experts _

<i>Paediatric pathologists:</i>	<i>Dr's Sheimberg, and Cary</i>
<i>Neuropathologist:</i>	<i>Dr Colin Smith, Dr David Ramsay</i>
<i>Ophthalmologists:</i>	<i>Professor Luthert and Dr Bonshek</i>
<i>Histopathologist:</i>	<i>Professor Malcolm and Dr Cohen</i>
<i>Paediatric Neurologist:</i>	<i>Dr Jansen</i>
<i>Endocrinologist:</i>	<i>Professor Nussey</i>
<i>Paediatric Neuroradiologist:</i>	<i>Dr Barnes</i>
<i>Paediatrics and Obstetrics:</i>	<i>Professor Miller</i>
<i>Biomechanics:</i>	<i>Dr Van Ee</i>
<i>Midwifery:</i>	<i>Professor Page</i>

We, as specialist barristers, advise on what experts should be approached: often it comes down to having done cases with them and what colleagues say.

Once we are in court though we stand alone before the medic and the expert: in Al Alas this meant that we, as barristers, had to unravel and explore the areas of concern arising from both the clinical mis/management of Jayden at UCL and the ramifications of GOSH's failure to detect radiological evident signs of rickets. We had to decode the x-rays and look at the medical records to explore the relevance of fluctuating CO2 levels or the lactate level. What was the significance of pulsometer readings of 100% saturation levels and how did this militate against a diagnosis of hypoxia? Had there been a deliberate policy of hypocapnia? In fact what was hypocapnia?

How much knowledge will the advocate have to have to know what facts and research and opinion to challenge?

Why science and the courts don't have all the answers: why both can get it wrong

There are few cases which inspire stronger views from not only the public at large but from the professionals who collaborate within the family justice system than cases concerning injuries alleged to have been inflicted and which demonstrate the TRIAD (encephalopathy, retinal haemorrhages and subdural haematoma). As Theis J observed in LBI v Al Alas & Wray [2012] EWHC 865 (FAM) at Para. 221:

'This is an area of some controversy with strong feelings on both sides of the medical profession.'

It is a complex area of medicine and there continues to be genuine disagreement amongst eminent experts often stridently expressed.

There is a real danger for children and families that cases in which experts are called to offer opinion evidence in relation to the TRIAD play out their own particular views, using scientific research selectively to reinforce their opinion in relation to fact and child specific situations.

As Professor Nussey observed in Al Alas "some of the papers were being used a bit like academic grenades and thrown into the argument to justify points rather than informing the discussion'. He said 'it is very difficult to make generalisations when you are dealing with something at one end of the spectrum" (para 156)

Experts are required to cite research to support their own theories and to alert the court of that science which might contradict their view: but is a case about a particular child an appropriate forum for any detailed and considered arbitration on the science?

Science moves on by challenge. It is fluid. It lags behind the medical cases that provide its facts for analysis. There is a risk of fossilizing judicial information and opinion.

Do we, whether advocates or judge, have sufficient scientific and medical expertise to trawl through the research, unpick its applicability to the case in hand, and apply and deploy it in cross examination or analysis of the experts that are called up before us?

As the legal profession struggles to keep up with the evolving science in relation to the TRIAD, the Court in care proceedings is enjoined to 'never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark R v Cannings [2004] EWCA Crim 1; [2004] 1 WLR 2607.

The exploration of the science within any particular case involving the TRIAD will be informed by a number of factors: -

- (a) The expert's selection and use of research materials in support of and contrary to their opinion evidence;*
- (b) The advocates' awareness and understanding of the research, which may need to go beyond that identified by the expert;*
- (c) the ability of the advocate to understand the science and to apply it to the clinical picture so as to cross examine the expert in real time relying only on knowledge and wits: there is no opportunity to 'phone a friend' or turn in court, as our criminal colleagues can, to ask the expert sitting behind them to decode the complex evidence being given so as to compose a rebuttal or pursue a forensic challenge.*

This is far from ideal.

Closing Remarks

Isn't it simply unrealistic to expect advocates who are not medics and who operate under time constraints and restricted funds to advance a forensic case with an appropriate degree of knowledge to inform an inquisitorial process considering such a complex area of science?

Do we not risk creating a lottery for those lucky clients who can be represented by those "in the know" on the science and those who unfortunately are not?

Has the time come to acknowledge that the inquisitorial imperative within our family justice system depends on the respective abilities of the advocates lined up on either side of the case? Whilst care proceedings are not adversarial proceedings, that's not how it feels to the parents of children who are threatened with permanent removal, nor is that how it is perceived by society at large.

There is an additional aspect to this concern. Many experts now actively consider whether they are prepared to

submit reports in family proceedings. They can feel unsupported within the family court by contrast to their experience of giving expert evidence in other litigation. From the expert's perspective, he/she has to rely on the skill and understanding of the advocate to draw out the relevant medical points for judicial consideration without being able to contribute to the advocates' understanding of the evidence. In a process in which their professional reputations may be at stake, this is unfair and threatens to reduce the pool of available experts further.

Expert reports are expensive disbursements. Of course, there is good reason given the constraints on the public purse, for family courts to scrutinise carefully a party's proposal to obtain and rely upon expert evidence. However, most practitioners will agree that even where the Court authorises expert evidence on the application of a Respondent party to care proceedings, it does not necessarily follow that the LAA will permit funding for the expert - even where the argument is won in principle, there will probably still have to be a hagggle over the hourly rate. The practical effect of this for publicly funded Respondent parties is that there is in reality a two-stage hurdle to expert evidence.

The well renowned experts are busy not only with their clinical and research commitments but are much sought after for their opinion evidence. Consequently, as a general rule, they tend to be more expensive, which may rule them out of giving evidence in family proceedings altogether. Even if the funding issue doesn't exclude them, they will probably take longer to report. It can be hard to circumvent a time-based objection to a particular expert in a system which operates under the general principle of s 1(2) Children Act 1989 that any delay in determining the question is likely to prejudice the welfare of the child. As a 26 week timetable is applied unless the deviation and delay can be objectively justified

Had the case of *Al Alas* required conclusion within 26 weeks there would have been no realistic prospect of obtaining the expert evidence which exonerated the parents in the family proceedings. The care trial would have preceded the criminal trial because the delay of some 2 years would have been unacceptable for Jayda. Following the parents acquittal at the criminal trial, it is likely that the parents would have had to apply to re-open any findings made. But without a child to whom the reopening of litigation would relate to there would be no point. If Jayda had been adopted by then then the parents would have no remedy

Adoption is a final step for the child:

- 'with the state's abandonment of the right to impose capital sentences, orders of the kind which family judges are typically invited to make in public law proceedings are amongst the most drastic that any judge in any jurisdiction is ever empowered to make. When a judge makes placement order or an adoption order in relation to a twenty year old mother's baby, the mother will have to live with the consequences of that decision for what may be upwards of 60 or even 70 years, and the baby may be upwards of 80 or even 90 years'
-
- *Re J (A Child)* [2013] EWHC 2894 (Fam)

If the child has already been placed for adoption, the prospects of being able to turn back time are remote (as in the case of *Re W (Children)* [2009] All ER 1156 - Appeal against existing Adoption Orders and earlier Care Orders on basis that original Care Order was a miscarriage of justice i.e. scurvy not NAI).

As I have said before: society needs a rational debate about how to balance the rights of a child when there is a conflict between a child's right to grow up in its family of origin and at the same time offer protection against parental abuse or neglect within that family. If a child is adopted on the basis of medical evidence that is subsequently found to be flawed the child and family have no remedy.

The debate on this issue needs to acknowledge the crippling financial constraints under which the family justice system operates.

Practitioners in this field are all too familiar with the daily complaints of local authorities that there are insufficient funds to ensure that the cases requiring their statutory intervention are adequately managed. The Family Courts are inundated with ever more applications and try to determine them as quickly as possible, yet work within finite restrictions imposed by availability of court rooms, judges and staff. Those practitioners who still represent the publicly funded parties in care proceedings face lengthy daily bureaucratic battles with the Legal Aid Agency (LAA) for funding approval each step of the way before they've even been able to think about case strategy. The potential for each or any of the above pressures to impact upon the welfare of a child should be self-evident.

Next lecture '2:1 Children or; why there is no typical family in a family court'

<https://www.gresham.ac.uk/lectures-and-events/two-point-one-children-why-there-is-no-typical-family-in-the-family-court>

This lecture will explore vulnerable parties and children in the Family Court, especially where the common

denominator is frequently one of poverty - in education, income and expectations. The range of disabilities that can be involved in court will be considered, and the way that law and practice responds to seek to protect an affected person's rights. The general principles which the court has to

address if it is to deliver a fair system to the most vulnerable will be outlined.

© Professor Jo Delahunty QC, 2017

[\[1\] BC v EF \(Parental Responsibility : Immunisation\) \[2016\] EWFC 69 \(05 December 2016\)](#)

[\[2\] Charlie Gard before Mr Justice Francis <http://www.telegraph.co.uk/news/2017/04/05/charlie-gards-mother-breaks-judge-says-impossible-situation/>](#)

[\[3\] E.g. NHS Trust v SR \[2012\] EWHC Fam 3842](#)

- **[\[4\] This was the Aysah King case that hit the news in 2014 \[4\] : circa 2015 having received the therapy the parents had fought to secure they were able to say he had recovered](#)**

[\[5\] 'Making Decisions to limit Treatment in life-limiting and life-threatening conditions in children; a framework for Practice' March 2015 3rd Ed Larcher V et al Arch Dis Child 2015 ;100 \(suppl 2 \); s1-23](#)

[\[6\] See Re KH \(Medical Treatment: Advanced Care POlan0 \[2013\]1 FLR 1471](#)

[\[7\] See for example NHS Trust v Child B and Mr and Mrs A \[2014\] EWHC 3486 \(Fam\)](#)

[\[8\] Per Ward J In Re A \(Children, Conjoined Twins: Surgical Separation\) \[2001\] Fam 147](#)

[\[9\] See Re KH supra](#)

[\[10\] Re J \(A minor\) \(wardship: medical treatment\) \[1991\] Fam 33 at page 46](#)

<https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Judgments/london-borough-islington-al-alas-wray-judgment-19042012.pdf>

[\[12\] E.g. the TRIAD \(subdural haematoma, encephalopathy and retinal haemorrhages\), as a hypotheses for explanation please see my last lecture <https://www.gresham.ac.uk/lectures-and-events/guilty-until-proven-innocent>](#)

[\[13\] s31 \(2\) Children Act 1989: A court may only make a care order or supervision order if it is satisfied—](#)

[\(a\) That the child concerned is suffering, or is likely to suffer, significant harm; and](#)

[\(b\) That the harm, or likelihood of harm, is attributable to—](#)

[\(i\) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or \(not relevant here\)](#)

(ii) The child's being beyond parental control.

'Harm' covers a wide range of ills: emotional, physical, sexual etc.[13]- we aren't talking about minor parenting shortcomings - the harm has to be 'significant'

[14] Please see my lecture <https://www.evensi.uk/crime-and-punishment-when-legal-worlds-collide-gresham/179133278> in which I explored the difference in outcomes between cases in the Criminal and Civil Courts, considered the framework of 'beyond reasonable doubt' versus 'the balance of probabilities' and the concept of the judge's role to determine the law and the jury the facts, as against the idea that the judge determines all (as in family cases)

[15] R 25v 4 a person may not without the permission of the court put expert evidence (in any form) before the court : the court may give permission for the instruction of an expert only if it is necessary to assist the court to resolve the proceedings.

[16] https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/practice-direction-25b-the-duties-of-an-expert,-the-experts-report-and-arrangements-for-an-expert-to-attend-court

[17] https://www.justice.gov.uk/courts/procedure-rules/family/parts/part_25

[18] See Dr Waney Squier and the judicial comments of Mrs Justice King (as she then was) in Re S [2009] EWHC 2115,

[19] (See the Experts Committee of the Family Justice Council Guidelines for the Instruction of Medical Experts from overseas in Family Cases, December 2011).

[20] <http://www.bailii.org/ew/cases/EWHC/Fam/2013/968.html>

[21] <http://www.bailii.org/ew/cases/EWHC/Fam/2013/968.html>