



**Response to the Chief Medical Officer's report on
medical expert witnesses: public consultation on
proposals for change**

*Bearing Good Witness:
Proposals for reforming the delivery of medical expert
evidence in family law cases*

RESPONSE

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About you: please use this section to tell us about yourself.

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2. Capacity in which you are responding to this consultation

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3. Do you have personal experience of the workings of the Family Court?

No

4. If so, in which capacity?

N/A

5. Are you under 18?

No

6. Date

28th February 2007

7. If you are representing a group or organisation, please tell us the name of the organisation and provide a summary of the people or organisation that you represent

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The National Society for the Prevention of Cruelty to Children

The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children. The NSPCC aims to end cruelty to children by seeking to influence legislation, policy, practice, attitudes and behaviours for the benefit of children and young people. This is achieved through a combination of service provision, lobbying, campaigning and public education.

The NSPCC believes that, given the will, all cruelty can be prevented. In order to achieve this, it is vital that all children, whatever their needs, have a range of services that are flexible and offer them support and protection. The NSPCC has more than 180 services in the UK and the Channel Islands. These services aim to:

- Prevent children being abused by working with parents and carers in vulnerable families to improve their knowledge and skills in safeguarding, and giving children and young people someone to turn to through ChildLine and our There4me.com online service.
- Protect vulnerable children and young people from abuse by providing direct services in a number of settings, including schools and young people's centres. We also protect them by providing Listening Services for adults to ensure they have someone to turn to with their concerns; by ensuring that abused children and young people are identified and effective action is taken to protect them, and by working with young people and adults who pose a risk to children and young people to reduce the risk of abuse.
- Help children and young people who have been abused overcome the effects of abuse and achieve their potential.

The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (UNCRC) was ratified by the government of the United Kingdom in 1991. Compliance with the articles is an obligation. Some of these articles are relevant when considering the provision of expert witness testimony in complex child care cases (author's emphasis):

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare Institutions, courts of law, administrative authorities or legislative bodies, **the best interests of the child shall be a primary consideration.**
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, **to this end, shall take all appropriate legislative and administrative measures.**

Article 9

1. States Parties shall ensure that **a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures,** that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.

The NSPCC considers that the provision of expert witness testimony in complex care cases will best serve the interests of the child if presented from the foundations of multi-disciplinary assessment. We consider this will contribute to the fulfilment of the requirements of Article 3.2, to take all appropriate administrative measures to ensure the child is afforded appropriate levels of protection, without compromising the requirements of Article 9, that a child shall not be separated from his or her parents without recourse to applicable procedures.

The NSPCC welcomes this opportunity to comment on the proposals to reform the delivery of medical expert evidence in family law cases. We consider the proposals in the report of the Chief Medical Officer (CMO) provide a strong foundation for reform of the system and will provide both better support for expert witnesses and a more robust structure for those commissioning them. In particular, we welcome the proposal at (xi) that “The knowledge and skills needed in all court settings should be taught as part of basic and continuing medical education [and] priority should be given to medical expert work in child protection cases.’

In addition, there are three issues which we believe would have benefited from (?) further consideration in these proposals. First, the “checklist” for providing “an early means of assessing the credentials of medical expert witnesses” (para 5.19, p.41) omits knowledge of child protection (need to say v briefly what the problem is). Secondly, we consider that there are occasions when the best interests of the child will be better served by the provision of expert evidence based on a multi-disciplinary model, and we discuss this in more detail below. Thirdly, while we recognise that the terms of reference for the review encompassed only the family courts, there is a pressing need to consider how these proposals might be extended and/or amended to apply to the Criminal Courts, of which brief mention is made in the consultation document.

Finally, it should be noted that where the NSPCC does not explicitly comment on particular questions it may be taken that we do not consider that we have sufficient expertise in these areas to respond authoritatively

The Credentials of Medical Expert Witnesses

The NSPCC welcomes the proposal to address the immediate concerns of competence and quality by provision of a “checklist” for the courts to establish the credentials of medical expert witnesses.

We strongly recommend that that some knowledge/competence in child protection issues should form a key component of the questions listed (p42), for example, ‘What child protection training have you received?’.

The Medical Expert Witness in Court Proceedings

‘ ... no *profession* is in a position to claim primary status or authority in child protection assessments to which others should defer.’

(Dale *et al*, 2005, p.156)

The NSPCC understands that there will always be occasions when the courts will require a medical expert opinion from an individual professional with expertise in a particular area (?), and we welcome the proposals to reinforce and quality assure the standard of evidence provided to the courts in these circumstances.

We note and welcome the guidance (para 2.2, p.13) that “by making more use of the evidence of ‘witnesses of fact’, which can also include social workers involved with the family” the demand for independent medical expert witnesses may be reduced, and we would argue that in many instances this may result in a more just and even-handed account of the circumstances and future potential of the individuals subject to care proceedings being available to the court.

Nevertheless, where expert witness services are sought, we consider that there are instances where the best interests of the child (and family) would be better served by a representative from a multi-disciplinary team, thereby achieving a holistic picture of both child and carer, taking into account both medical and social models of care and capacity, and enabling the medical expert, where called, to present more informed testimony. In this model, a multi-disciplinary court report is provided, informed by a multi-disciplinary assessment. Expert witness evidence is provided by a nominated member of the multi-disciplinary team, and the court retains the power to call other experts from within the team as it deems necessary. This is not to disregard the importance or relevance of medical evidence; it is, however, to underline the fact that most child care cases are distinguished by uncertainty, where judgements are better informed by a thorough understanding of the multi-dimensional aspects pertaining to the individual case.

The efficacy of a multi-disciplinary dimension is further underlined in the joint report of the Department for Constitutional Affairs (DCA), Department for Education & Skills (DfES) and the Welsh Assembly Government:

‘There may also be a need for further assessment – ‘welfare assessments’ – to assist the court in ascertaining what disposal will be in the best interests of the child. ... These welfare assessments are currently conducted by independent experts: **in future they should consist of one multi-disciplinary assessment of the family by a multi-disciplinary team of professionals over a limited timeframe ...** ‘ (author’s emphasis)

(Review of Child Care Proceedings System in England & Wales, 2006)

The Multi-disciplinary Specialist Assessment Model

In presenting the case for a multi-disciplinary model, the NSPCC acknowledges the long-standing concerns around the quality and consistency of court reports and court skills on the part of, in particular, social workers. We are conscious of the need for education and skills building within the discipline, and, together with the CMO (para.2, p.11), we welcome the proposed improvements to social workers’ court skills, proposed by the Association of Directors of Social Services.

The NSPCC provides a specialist assessment service which serves a wide area of London and the South East.

The NSPCC Parkside Project

The NSPCC Parkside project works with mental health professionals in a multi-disciplinary framework. The team will often 'twin-track' the specialist assessment of children with provision of therapeutic support. They will also provide therapeutic services for parents, who may be struggling with issues such as substance abuse, that impact on their parenting capacity.

A significant proportion of the children and young people with whom the team work are in care pending the outcome of court proceedings. Our services are likely to inform second stage care proceedings, where matters of 'disposal' and 'welfare' come under consideration.

As a specialist service, our multi-disciplinary team acts in an expert witness capacity in complex court proceedings. Following on-going multi-disciplinary assessment over an extended period, a multi-author report is produced and a nominated member of the team (not necessarily a doctor) will present expert evidence to the court if/when called upon to do so. The court may also seek evidence from other members of the multi-disciplinary team.

The team is generally commissioned to assess families in which children have experienced abuse or neglect over a long period of time. Many parents in these circumstances have their own experiences of abuse, and frequently additional difficulties, such as substance misuse or mental health problems. Commissioners will typically ask the team to assess the impact of a child's family life on his/her development, the capacity of parents to change and to advise what should happen to the children in the future. Specialist assessment is most often sought because of the independence it brings to difficult and complex cases, but independent teams also add value by maintaining a clear child-focus, by avoiding *drift*, and by encouraging others to keep a child's particular needs at the forefront of their minds.

Assessments take place over an average 16-week period, though it is not unusual to work with a child for longer.

We believe this model of assessment and expert witness provision bears further consideration, and we would be happy to arrange a visit to this service to enable the CMO and/or his delegated official(s) to engage in discussion of how such teams might be formed and facilitated.

Expert Evidence in the Court

The NSPCC understands that the scope of these proposals does not include criminal court proceedings, and we respect the CMO's decision to proceed with caution before introducing the "... considerable change and new ways of working." to proceedings in this context. *However*, there is a pressing need to address the role of the medical expert witness in criminal court settings, and it is not clear that these proposals will comfortably transfer from the inquisitorial environment of the family courts to the adversarial environment of the criminal court, which also operates different standards of the burden of proof (balance of probability and beyond all reasonable doubt, respectively).

Recent survey data (Cochrane, 2006) implies that doctors were asked about their medical expert witness work in *all* court settings, and certainly the repeated statement that doctors find the adversarial process intimidating and off-putting (pp 5,6,7,20,22,26) suggest that it is criminal court proceedings that may be having the most significant impact on the supply of medical expert witnesses,

In this context, the NSPCC has long-standing concerns around the problems of achieving criminal convictions when a child dies or is seriously injured by parents or carers (NSPCC, 2003), which are unlikely to be addressed by this proposal. We would therefore, urge early consideration of reform to the delivery of medical expert evidence in criminal law cases.

1. General

1.1 Do you think that these proposals, taken together, will tackle the issues of quality and supply of medical expert witnesses in the family courts?

We consider that the issue of supply is well addressed in the proposals and that the significant emphases on training will, over time, equip medical professionals with the skills and confidence to undertake this work.

We consider the issue of quality is less well addressed and bears further reflection.

1.2 If so, what are the main ways in which they will help?

Supply

We broadly welcome the proposal for the development of '...a competence-based syllabus for court skills. Within [which] priority should be given to medical expert work in child protection cases.' Brophy (2006) identifies that '[T]he availability of sufficiently trained and experienced psychologists and child psychiatrists for child protection proceedings remains a problem ...'. We believe implementation of proposal 11 will contribute to a wider and better informed pool

of medical expertise, particularly in light of the recent findings by Cochrane (2006) that non-consultant grades in particular do not feel qualified to act as medical expert witnesses.

1.3 **If not, why not? Can you suggest other ways of tackling the issues of quality and supply?**

Quality

The NSPCC considers that a multi-disciplinary team consists of experts from *different* disciplines e.g. medicine, social care, education *et al.* An inter-disciplinary team is made up of different specialities from within the same discipline e.g. paediatricians, psychiatrists, paediatric radiologists *et al.* from medicine.

The consultation paper focuses its attention on what are referred to as *multi-disciplinary* teams. However, we consider that the key thrust of the teams described is in fact *inter-disciplinary*, the predominant application being teams of clinicians from different medical specialities. The use and value of *multi-disciplinary* teams is significantly understated.

Child care cases are typically characterised by a variety of factors, many of which fall outwith the context of medical expertise, and are distinguished by varying degrees of uncertainty. In these instances the use of independent multi-disciplinary teams, together with multi-author reports, is appropriate, and of particular value, where cases are complex, requires inputs from different professionals and where those inputs require detailed and effective co-ordination within a relatively short period of time (Cotmore & Webley, 2006). In addition, the value-added element of independent specialist assessment lies in its potential to equip professionals from a variety of disciplines with rigorous and well evidenced empirical material, derived from a holistic assessment of the individual child(ren) and his/her/their family. We believe that when professionals are prepared and empowered in this way will the issue of quality will be fully addressed.

Annex A:

Consultation questionnaire

2. Supply of medical expert witnesses (teams) by the NHS

(See proposals 1–6 of *Bearing Good Witness*.)

2.1 Do you perceive any practical problems with the proposals for providing medical witness expertise from within teams in the NHS?

Yes.

2.2 If so, what?

Notwithstanding paragraph 4.6, sub-paragraph 1¹, we are concerned that the key thrust of these proposals remains focused on the provision of *inter*-disciplinary, rather than *multi*-disciplinary teams in a predominantly medical context (see also comments at 1.3 above). In this environment we believe the contributions and insights of non-medical professionals are likely to be at best devalued and at worst not sought.

In addition, and given the well documented fiscal problems currently being experienced by the NHS, we do not believe that the wholesale shift of medical expert witness provision into the non-core business of the NHS is timely, nor that it will receive an appropriate level of understanding or priority in the current climate.

2.3 Do you have personal experience of working in or with teams of this sort and, if so, what is your relationship with the team, eg social worker, lawyer, doctor or other medical specialty?

No. However, the provenance of our comments is clearly stated in the penultimate paragraph of the introduction to this response.

2.4 If so, what do you perceive as the advantages and disadvantages of providing medical evidence for the courts in this way?

No comment.

¹ ‘...{T}he key feature of existing speciality and/or multi-disciplinary teams are :

- A mix of doctors from various specialities, and other professions such as clinical psychology, social work, family therapy and health visiting’

2.5 **If you agree that the NHS should provide teams, how do you think this might best be managed?**

We state in our introduction that we consider the proposals provide a strong foundation for reform of the system and will provide both better support for expert witnesses and a more robust structure for those commissioning them. We therefore, broadly agree that medical expert witnesses should be commissioned from within teams located within the NHS. We are concerned however, that the NHS may not currently have the capacity to do so (para. 2.2 above).

We also state the case, above, for multi-disciplinary court reports presented by a nominated team lead, who is not necessarily a doctor. It is not intuitively obvious that the most appropriate place for multi-disciplinary teams of this sort is within the NHS. It is possible that a mixed economy of provision – with a combination of NHS-based teams, and teams located elsewhere that include medical professionals – might be the most appropriate for addressing all the issues we have raised, though the detail of how this would work would require further consideration.

3. Commissioning the service

(See proposals 7–9 of *Bearing Good Witness*.)

3.1 **Should the current system move from multiple, ad-hoc, case-by-case arrangements to a service commissioned from the NHS by a commissioning organisation?**

There is a substantive case for moving from multiple, ad-hoc, case-by-case arrangements, to a more structured arrangement, not least to address issues of quality and impartiality, and to move “supply away from the current reliance on medical expert witnesses who are acting in a private capacity.” (para 1.13, p.12).

However, as we state above (2.5), if our proposal for the consideration of multi-disciplinary teams is adopted, the NHS may not always be the only, or the most appropriate, place for these teams to be located (see Parkside case study, above, p.7)

3.2 **Of the possible public-sector organisations that could hold a contract with the NHS at local or regional level to provide medical witness expertise, which do you consider to be the most appropriate out of those listed at paragraph 4.22 of the report?**

Please see paragraph 3.4 below.

3.3 **If you do not think any of these possibilities would work, how might these arrangements be managed in future?**

Please see paragraph 3.4 below.

3.4 **Do you foresee any practical problems with the proposals for change in the way the service is commissioned?**

In general the NSPCC embraces the principle of independence in the commissioning of services, particularly where the potential (or the perception of potential) exists of vested interests.

3.5 **If so, please specify what, and how they might be overcome?**

We would recommend that the CMO should consider consulting with appropriate voluntary sector agents, such as the Children's Legal Centre, to explore the possibility of creating capacity within the sector to undertake independent commissioning for specialist court reports.

3.6 **How do you think these proposals might best be implemented?**

See 3.5 above.

3.7 **Do you think there is scope for improving the way that instructions are issued or budgets are managed (proposal ten) and, if so, how?**

No comment.

4. Education and training

(See proposals 11, 13 and 16 of *Bearing Good Witness*.)

'Doctors sometimes fail to appreciate that there is a difference between the role and expectations of professional and expert witnesses. Sometimes doctors may appear in their professional capacity describing their treatment of a patient. At other times, they will be expected to attend as experts, able to express an opinion but founding their views on a scientific base. Unfortunately, there is insufficient training emphasis on the necessity of a scientific foundation for expert testimony.'

(RCP & RCPCH, 2004)

Our comments on this section are based on the broad and extensive experience the NSPCC has in developing and providing training programmes and activities for social care and allied professionals.

It is quite clear from the evidence that a call for expanded and improved training will be welcomed in many quarters. Guardians have called for improvements in the training of Child and Adolescent Mental Health professionals; parents would welcome training for judges and magistrates (Brophy, 2006), and a need for single and multi-agency training for clinicians was identified by Brophy *et al* as long ago as 2001, and reinforced by the Royal College of Pathologists (RCP) and the Royal College of Paediatrics and Child Health (RCPCH) in 2004.

We therefore warmly welcome the emphasis placed upon education and training in this document.

Notwithstanding the scope of these proposals, however, we urge the CMO to consider and ensure that the development of training and competencies pays due consideration to the requirements of the Criminal Court if medical expert witnesses are to be enabled to “apply their work knowledgeably and responsively in the context of court processes”. (para 1.13, p.13)

4.1 **How and when should doctors be equipped with the knowledge and skills necessary for work as medical expert witnesses in the family courts?**

There is, perhaps, no defined point at which doctors should be equipped with the knowledge and skills necessary for work as medical expert witnesses. The NSPCC advocates a significant element of child protection training for all doctors at all levels, though this is unlikely to address the particular knowledge and skills required of an expert witness. We therefore welcome the proposal for training in medical expert witness skills to begin at undergraduate level, and to continue at postgraduate level.

Self-evidently, however, there is no end-point, at which training can cease. It is important that all individuals proposing to engage in expert witness work recognise the relevance of maintaining their expertise not simply through their practice, but by supplementing this with a wider, and in particular multi-disciplinary, dedicated training element.

There are six expert witness disciplines identified in the paper: adult psychiatrists and psychologists; child psychiatrists and psychologists; social workers; paediatricians; residential assessors and physicians. A significant minority of reports (24 per cent) are provided by ‘other experts’. **We recommend that training within specific disciplines should take place under the auspices of the appropriate professional bodies, with multi-disciplinary training taking place within the context of the proposed new multi-disciplinary teams. It**

would be appropriate for a mechanism to be in place between professional bodies to ensure consistency across and between them.

It is not clear whether 'other experts' will continue to have a role if multi-disciplinary teams are formed. However, the validity of expert witness evidence might be further assured through the use of the proposed accreditation scheme. Accreditation would have the additional benefit of providing commissioners with some assurance of the individual and collective utility of the teams they may be commissioning, whilst providing teams themselves with the flexibility to second individual experts, either from other teams or from independent sources, where a shortfall of expertise is identified within their own team (see also comments below).

4.2 Do we need a different training scheme for new doctors than for existing doctors?

As stated at 4.1.above, the NSPCC advocates a significant element of child protection training for all doctors at all levels. Encouragingly, child protection is now a mandatory part of paediatric training, and with this in mind, the NSPCC in collaboration with the Royal College of Paediatrics and Child Health (RCPCH), developed *Safeguarding Children - Recognition and Response in Child Protection* (2006). This training package is of recognised RCPCH standard and is being used (though not exclusively) as part of the continuing professional development of both qualified paediatric doctors, and those in training. The training is also suitable for other medical professionals, including General Practitioners.

We acknowledge that this training does not address the particular skills and requirements of those professionals providing medical expert evidence. *However*, we believe that medical, and in particular paediatric and child psychiatric, professionals will be more confident and thus more inclined to engage in medical expert witness work, *if* they have a sound foundation in recognising and responding to child protection concerns.

Finally, and bearing in mind the aim of the proposals to "secure a sustainable supply of competent, quality-assured medical expert witnesses for care and supervision cases in the future", (para. 1, p.3) the NSPCC would welcome the opportunity to assist further in the development of training for court skills.

4.5 Would a National Knowledge Service support medical expert witnesses in their work?

We broadly welcome the proposed establishment of a national body to provide advice and support to medical expert witnesses. We particularly value the proposal that such a body would act as a clearing house for the identification and

dissemination of research information, and the identification of gaps for the commissioning of appropriate research.

5. Quality assurance and regulation

5.1 Is accreditation the best way of ensuring the future quality of the medical expert witness service?

We believe there is merit in the development of a model of accreditation (see also comments at 4.1 above), and that this will go some way towards assuring the quality of the service.

5.2 If so, how might accreditation work in practice?

The accreditation model will need to be two-tier, to enable teams as well as individuals to become accredited.

It would seem appropriate to link any model of accreditation to training, so that individual accreditation is awarded by the relevant professional bodies, linked with the assurance that appropriate training has been undertaken and assessed alongside the amount, extent and timeliness of practice experience. In this way there is a level of assurance around individuals, who may then 'move' their expertise around as required, for example within regional clusters of teams.

Team accreditation might then be based on (a) an assessment of the experience, training and level of accreditation of individuals within the team, together with (b) an assessment of the extent and quality of multi-disciplinary training with which the team has jointly engaged.

5.4 How could an accreditation system be established and by whom?

A system of accreditation should be established by the relevant professional bodies. As with training (see paragraph 4.1 above) there will need to be a co-ordinating mechanism to ensure consistency.

Team accreditation might be established through joint inspection bodies, for example the Healthcare Commission and the Commission for Social Care Inspection (CSCI) or its successor body.

We recommend that a system of accreditation, related to continuous professional development and training be developed.

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REFERENCES

Brophy, J (2006). *Research Review: Child Care Proceedings under the Children Act 1989*. London, Department for Constitutional Affairs. Research Series 5/06.

Brophy J, Brown L, Cohen J & Radcliffe P (2001) *Child Psychiatry and Child Protection Litigation*. London, Gaskell Press.

Cochrane, H (2006). *Medical Expert Witnesses: An analysis of survey data provided by doctors using Doctors.net.org*. London, Department of Health, Standard & Quality Analytical Team

Cotmore, R and Webley, S (2006). *Evaluation of Specialist Assessment Services*. London, NSPCC

Dale, P; Green, R; & Fellows, R (2005). *Child Protection Assessment Following Serious Injuries to Infants: Fine Judgements*. Chichester, John Wiley & Sons Limited

Department for Education & Skills with The Department for Constitutional Affairs (2006). *Review of the Child Care Proceedings System in England and Wales*.

Legal Services Commission (2004). *The Use of Experts: Quality, price and procedures in publicly funded cases. A Consultation Paper*. London, Legal Services Commission.

NSPCC (2003). *Which of you did it? Problems of achieving criminal convictions when a child dies or is seriously injured by parents or carers*. London, NSPCC

Royal College of Pathologists with Royal College of Paediatrics & Child Health (2007) *An investigation into the nature and impact of complaints made against paediatricians involved in child protection procedures*. Retrieved, February 2007 @ http://www.rcpch.ac.uk/publications/recent_publications/complaints%20full%20report.pdf

Royal College of Pathologists with Royal College of Paediatrics & Child Health (2004). *Sudden unexpected death in infancy: A multi-agency protocol for care and investigation. The report of a working group convened by The Royal College of Pathologists and The Royal College of Paediatrics and Child Health*. Retrieved, December 2006 @ www.rcpath.org and www.rcpch.ac.uk.

The Royal College of Paediatrics and Child Health (2004). *Survey on Child Protection Complaints*. Retrieved, February 2007 @ www.rcpch.ac.uk/publications/recent_publications/Latest%20news/CP%20report.pdf