

1 The Children Act 1989: a new landscape for the work of expert witnesses

The Act – a milestone in family proceedings

The Children Act 1989 was implemented on 14 October 1991. It aimed to revolutionise practice and proceedings concerning the welfare of children in England and Wales. The Act started from the principle that the primary responsibility for the upbringing of children rests with families, and that for most children their interests will be served best by enabling them to grow up in their own family. But changes brought about by the Act also reflected considerable concern and dissatisfaction with professional services for children following, for example, the Cleveland inquiry into child abuse and the deaths of children such as Jasmine Beckford, Kimberley Carlile and Doreen Aston while in their parents' care. Equally, the juvenile court was deemed inappropriate for care proceedings, as was also the dominance of a rescue over a preventive or respite approach to dealing with children considered to be at risk in their parents' care.

The Act therefore sought to achieve a better balance between reinforcing the autonomy of the family and enabling parents to exercise their parental responsibilities without state interference, and state support and protection of children where parents were failing or unable to meet their needs. Thus, it provided for support from local authorities for families where children were defined as 'in need',¹

¹ Section 17 of the Children Act 1989 (local authority provision of services for children in need and their families), as outlined in *The Children Act Guidance and Regulations* (Department of Health, 1991*b*; see also Aldgate & Turnstill, 1996).

2 *Child psychiatry and child protection litigation*

and also changed practice and procedures for the protection of children where there were concerns about child neglect or maltreatment. But the Children Act and its accompanying guidance (e.g. Department of Health, 1991*a,b*) did much more than simply change law and procedures for children deemed at risk: it also had implications for the work of all professionals and agencies involved in child protection work. It was not important simply because it was the first consolidating and comprehensive piece of legislation aimed at children and families for 50 years, but also because it was the outcome of a substantial amount of debate and public consultation about law, legal procedure and the philosophy and principles that should underscore changes in this field.²

The scope of the Children Act and its accompanying philosophy is extensive. It brought together both private and public law within one framework, it changed the structure and functioning of courts hearing family proceedings (see below),³ and with regard to public law, importantly, it sought to achieve a better balance between the protection of children considered at risk and the need to ensure parents are able effectively to challenge state intervention. The aim was also to encourage greater partnership between statutory authorities and parents⁴ and to promote the use of voluntary rather than compulsory arrangements between parents and local authorities wherever possible. Equally, the Act and guidance aimed to ensure that children and young people are consulted and are as fully informed as possible in actions and decisions about them. This is emphasised in the requirements for courts and professionals to consult with children and their parents and others and to take their wishes and views into consideration, and by giving children themselves the right to apply for court orders, and also by recognising in principle the rights of mature children to refuse consent to medical or psychiatric examinations. In addition, the Act and guidance recognised that issues of 'race', culture, language and religion are

²Several Law Commission papers on family law underscored the original Bill (e.g. Law Commission, 1986, 1987). The history of the public law aspects of the Act, beginning with the Short report (House of Commons, 1984) and the subsequent interdepartmental working party on child care law which reported in 1985 (Department of Health and Social Security, 1985), coincided with the production of working papers by the Law Commission and is reviewed by Ryan (1994, pp. 1–2).

³For example, although the Act failed to introduce a proper family court structure, it did introduce a 'concurrent jurisdiction' – see below.

⁴Although the word 'partnership' does not appear in the legislation and regulations, it did occur in government guidance on the Act and in the Department of Health's list of principles that should underpin practices (Department of Health, 1989, 1991*d*, 1995).

crucially important when courts and local authorities are making decisions about children.⁵

The principles that guide the courts

The main principles that apply to all proceedings concerning the upbringing of children brought under the Act are:

- (a) the child's welfare shall be the court's paramount consideration (section 1(1));
- (b) a checklist of factors must be considered by courts when certain decisions are being made (section 1(3) – see below);
- (c) delay in deciding questions concerning children is likely to prejudice their welfare (section 1(2));
- (d) a court should not make an order under the Act with respect to a child unless it considers that making one would be better for the child than making no order at all (section 1(5)).

A new court structure for family proceedings

Concurrent jurisdiction

The relevant courts for cases under the Act are the magistrates' courts, which are called 'family proceedings courts' when hearing both private and public family law cases, the county courts (some of which are designated 'family hearing centres' for hearing private law applications, and a smaller number of which are designated 'care centres' for hearing public law applications), and the Family Division of the High Court.⁶ Concurrent jurisdiction means that all these courts have the same powers regarding the range of orders available under the Act.

⁵ Section 22(5)(c) and section 1(3) (the welfare checklist). Although there is no specific reference to race, culture, religion and language as such in the checklist, section 1(3)(d) does cover 'his age, sex, background and *any characteristics* [emphasis added] of his which the court considers relevant', thus arguably allowing for a consideration of these issues.

⁶ In the family proceedings courts, all Children Act cases and other family proceedings are heard by magistrates from the court's family panel. These should consist of three justices with at least one man and one woman. With regard to the county court, there are three types of circuit judges nominated to deal with family proceedings. These are *designated* family judges (based at care centres and with full powers to deal with private and public law cases), *nominated* judges (also based at care centres and with full jurisdiction to hear private and public law cases) and *circuit* family judges (dealing with private law cases only).

4 *Child psychiatry and child protection litigation*

Moreover, cases can be transferred to a higher court, a lower court or to another court at the same level (e.g. from one family proceedings court to another).⁷

Court control

In both private and public law cases, the court is now required to establish a timetable for cases and to give directions for the preparation of cases to ensure that they are ready for a final hearing. Directions hearings were introduced, with two main purposes: to enable courts to exert control over the direction, substance and evidence in cases, and to deal with procedural issues to ensure cases are ready for the final hearing with a minimum of delay. Directions hearings are held in all tiers of the court structure. Practices may vary slightly depending on, for example, whether directions are complex or contested and whether they are being sought along with an interim application, but directions hearings generally take place before a district judge or circuit judge in the county court care centre and High Court, and before a justice's clerk in the family proceedings courts. However, if the issues for which direction of the court is sought are contested or complex, a directions hearing may be before a family panel of magistrates, stipendiary magistrate, or a district, county or High Court judge.

Starting proceedings

The relevant court for beginning public law cases under the Children Act is the magistrates' family proceedings court.⁸ But a case may be transferred to the relevant care centre⁹ if the case is of exceptional gravity, importance or complexity, for example where there is or may be complicated or conflicting evidence or where there is a multiplicity of parties and cross-applications, or where a case raises an important point of law or public policy.¹⁰ Also, a case may be transferred if there is a need to consolidate it with other proceedings, for example where proceedings concerning the child in question, or another child in

⁷ Children (allocation of Proceedings) Order 1991 SI 1991/1677 (and later case law): the rules governing transfer are set out on p. 4.

⁸ Unless they have been started as a result of a section 37 direction by a county court or High Court, or there are continuing public law proceedings concerning the same child going on in another court. In these circumstances proceedings should start in that court (article 3, Children (Allocation of Proceedings) Order 1991).

⁹ Or the Principal Registry if the case emanates from the magistrates' family proceedings court serving the London boroughs.

¹⁰ Article 18(3), Children (Allocation of Proceedings) Order 1991.

the same family, are underway in another court. In addition, it is also possible to transfer a case where this would 'significantly ... accelerate the hearing'.¹¹ Any party to proceedings can request that the case be transferred to a higher court, and a court can decide of its own volition to transfer a case.

The guardian ad litem

In all specified proceedings (i.e. all public law applications, including those to place children in secure accommodation and applications for emergency protection orders) the court must appoint a guardian ad litem for the child 'unless it is not necessary to do so in order to safeguard his interests' (section 41(1)). This appointment should take place as soon as possible following a court application. The background and the development of the role and duties of the guardian ad litem following the Children Act 1989 are outlined and discussed by Brophy & Bates (1999, p. 7).¹² In brief, guardians are under a duty to safeguard the interests of the child and they appoint and instruct a solicitor to act on behalf of the child.¹³ They have to act in accordance with the welfare principle – the child's welfare is paramount – and with the principle that delay is prejudicial to children. Guardians also have to consider all the factors in the welfare checklist (see below) when carrying out their duties. In addition, as officers of the court, guardians are under a duty to advise the court on matters such as timetabling, the appropriate court for hearing a case, the use of expert evidence, the wishes and feelings of children and a child's level of understanding, for example in consenting to medical examinations. Equally, guardians advise the court of the options available to it and the suitability of each option.

Guardians investigate the background to the case and read the local authority files to scrutinise the local authority's conduct of the case. They also have the right to copy any documents relevant to the child and are under a duty to attend all directions hearings unless excused by the court.¹⁴ They can be asked to produce interim reports during proceedings and they must produce a final report, which must be served on other parties to proceedings.¹⁵

¹¹ Article 7(1), Children (Allocation of Proceedings) Order 1991.

¹² And national standards for the work of the guardian were introduced by the Department of Health (1996).

¹³ Unless a child wishes to instruct a solicitor him- or herself and is considered of sufficient understanding to do this.

¹⁴ Rule 11(6), section 42, and rule 11(4).

¹⁵ Rule 11 (7).

6 *Child psychiatry and child protection litigation*

Thus, the guardian's role is extensive, and the work of the guardian was, and is, seen as crucial to the success of the Children Act. Their duties and responsibilities involve both reflecting back and looking forward. The former (investigative) task entails examining how child protection and family support work have been organised by a local authority with a particular family. This includes interviewing such persons as the guardian thinks appropriate¹⁶ (or as directed by the court). It also entails an examination of local authority records and an assessment, for example, of the extent to which a local authority has attempted to work in consultation and partnership with a family on a voluntary basis, thus alleviating the need for compulsory intervention. It will also entail examining the degree to which a child and parents have cooperated with statutory agencies. Moreover, since court rules make special provision regarding an examination or an assessment of a child – no child may be seen by an expert for the purposes of preparing a report for the proceedings without permission of the court¹⁷ – the guardian has to consider at an early stage in proceedings whether there is any need for expert assessments or examinations. The guardian is thus expected to play a full and active role, not only as the representative and spokesperson for the child, but also as an adviser to the court on both procedural and evidential issues.

Local authority support for children and families

Part III and schedule 2 of the Children Act 1989 deal with local authority support for children and their families and it outlines a range of duties and powers for local authorities with regard to the provision of services for children 'in need'. So, for example, it details the law regarding the provision of accommodation for children by local authorities and introduces the new concept of children being 'looked after' by the local authority. This term now applies to children who come into local authority care either voluntarily (i.e. as a result of choice by parents or children) or as a result of statutory intervention resulting in a care order under section 31 of the Act (see below).

The background to the term 'family support', which was used in the government's *Review of Child Care Law* (Department of Health and Social

¹⁶ Guardians must decide how detailed their enquiries should be, but the list includes not simply parents and other adults who are important to the child – it also extends to any siblings, members of the child's extended family and other professionals such as health visitors, general practitioners, school teachers, and so on.

¹⁷ FPC (CA 1989) R 1991 r 18(1); FPR 1991 r 14 18(1).

Security, 1985), and the development of the duties of the local authority to provide services to prevent the need for children to come into care are reviewed by Ryan (1994, pp. 23–57), as are the child protection procedures undertaken by local authorities before the instigation of care proceedings (pp. 59–72). That background provides the framework for understanding the role of the guardian ad litem not only in assessing the extent and quality of the pre-court work undertaken by local authorities, but also in reviewing the need for any additional specialist assessments beyond those of social workers, for example by child psychiatrists.

Under the Act, local authorities have a general duty:

- “ (a) to safeguard and promote the welfare of children within their area who are in need, and
- (b) so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children’s needs.” (Section 17(1)).

The general duty embodies two important principles underlying the Act: first, the desire to have legislation that positively promotes family support work; and second, the belief that the welfare of the majority of children will be safeguarded best by enabling them to grow up within their own family. Because local authorities have a duty to reduce the need to initiate care or supervision proceedings, when they are considering making an application for a care or supervision order (see below), whether in the context of existing court proceedings or as part of a child protection investigation, they must consider what other options might be available (para. 7, schedule 2 of the Act). In other words, a care or supervision order should be sought only where there appears to be no better way of safeguarding and promoting the welfare of the child; thus, voluntary arrangements through the provision of services to the child and family should always be fully explored (Department of Health, 1991a, para. 3.2).

Proceedings for care and supervision applications

Part IV of the Children Act 1989 deals with disputes between parents and the state regarding the care and upbringing of children. Many of the changes introduced by the Act were a response to sustained criticism about the complexities, anomalies and injustices of previous legislation. For example, as outlined by Ryan (1994, p. 97): children could come into proceedings via a variety of routes, with varying criteria for entry; the legal position of children differed depending

8 *Child psychiatry and child protection litigation*

on which route had brought them into care; local authorities could assume parental rights by an administrative procedure; children, parents and other relatives were unable to challenge local authority decisions about contact with children in care – save in limited circumstances; and there was unequal access to the wardship jurisdiction of the High Court.

Most of these anomalies and injustices were tackled by the Children Act in an attempt to achieve a better balance between the needs of children for protection and the rights of parents to participate fully in proceedings – even though some new problems have emerged (see Brophy & Bates, 1998). Thus, under section 31(1), only the local authority or an ‘authorised’ person (e.g. the National Society for the Prevention of Cruelty to Children (NSPCC) or any of its officers – section (9) (a)) can make an application for a care or supervision order and the local authority can no longer use the inherent jurisdiction of the High Court for such purposes. Parents are able to challenge local authority decisions, children are separately represented, the guardian ad litem reviews the work undertaken by the local authority with a child and parents and makes recommendations in respect of the paramount welfare of the child, and where members of the extended family have a distinct interest in the proceedings they can apply to the court to become parties in proceedings.

Under section 31(2), the Children Act sets out a single set of conditions that must be established before the court can consider whether to make an order under the Act. These conditions, called the threshold criteria, are:

- “ (a) That the child concerned is suffering, or likely to suffer, significant harm, and
- (b) That the harm or likelihood of harm, is attributable to –
 - (i) That care given to the child, or likely to be given to him were the order not made, not being what it would be reasonable to expect a parent to give him; or
 - (ii) That the child’s being beyond parental control.”

The ‘significant harm’ criteria

The definition of ‘harm’ in the Act, defined by section 31(9), centres on ill treatment or the impairment of health or development. ‘Ill treatment’ is defined as including sexual and physical abuse and forms of ill treatment that are not physical (e.g. mental). Impairment of health or development can also provide the basis of ‘harm’. ‘Health’ is defined as physical or mental health, while ‘development’ is defined as physical, intellectual, emotional or behavioural development. White (1998) usefully defined the thinking and assessment exercise

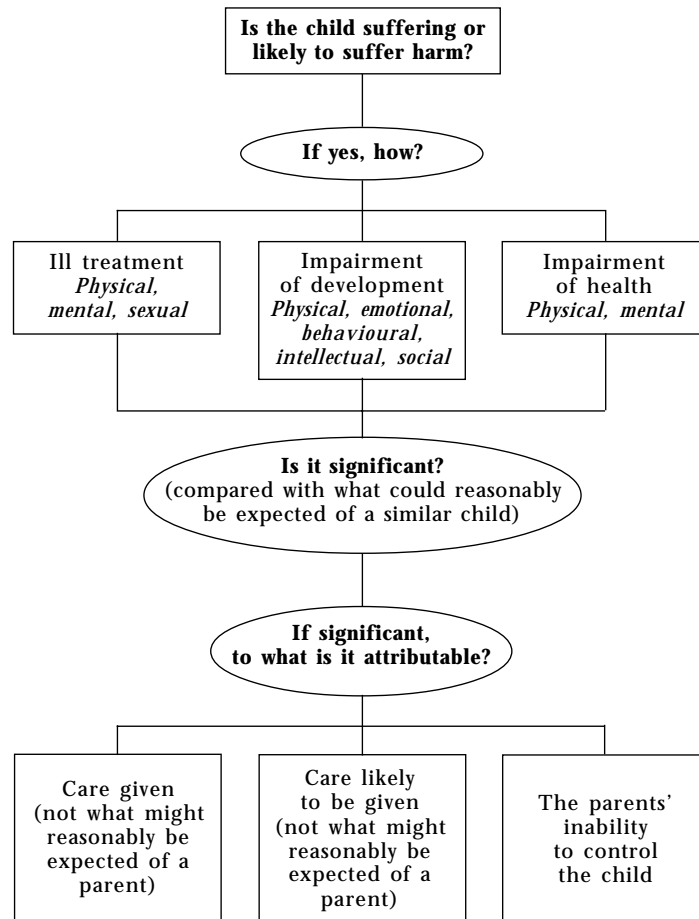


Fig. 1. The criteria for significant harm. Source: White (1998, p. 19); redrawn with permission.

indicated by the criteria for significant harm in terms of a series of 'steps'. These are shown in a flow diagram in Fig. 1.

While there was no definition of 'significant' when the Bill was debated, the Lord Chancellor said, "It speaks of significant harm – namely that which, being more than minimal, indicates that compulsory care or supervision may be justified".¹⁸ In early guidance, the Department of Health (1991a, para. 3.21) argued that "minor

¹⁸ Hansard, House of Lords, 19 January 1989, col. 343.

10 *Child psychiatry and child protection litigation*

shortcomings in health care or minor deficits in physical, psychological or social development should not require compulsory intervention unless cumulatively they are having, or are likely to have, serious and lasting effects upon the child”.

Where the facts relate to health or development, it is also necessary to compare the health or development with what could reasonably be expected of a similar child (section 31(10)). This test has raised several questions about interpretation of ‘a similar child’; for example, Ryan (1994) and White (1991) questioned whether a different test might apply depending on demographic, socio-economic and ethnic status.¹⁹

The threshold conditions require evidence on two issues before they can be established. The first is establishing the existence, or likely existence, of significant harm at the date of the commencement of the protective proceedings, and the second is establishing that the harm is attributable to a lack of reasonable parental care. The court must then go on to consider the welfare principle, and to determine whether or not the order would be better for the child than no order at all (section 1(5)). In considering what order to make, the court is instructed to have regard in particular to a welfare checklist set out in section 1(3)):

- (a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);
- (b) his physical, emotional and educational needs;
- (c) the likely effect on him of any change in his circumstances;
- (d) his age, sex, background and any characteristics of his which the court considers relevant;
- (e) any harm which he has suffered or is at risk of suffering;
- (f) how capable each of his parents, and any other person in relation to whom the court considered the question to be relevant, is of meeting his needs;
- (g) the powers available to the court under this Act in the proceedings in question.

A new landscape for experts

The above changes to law and legal procedure and the philosophies on which these changes were based presented a new and very different

¹⁹ The Department of Health (1991a, para. 3.20) argued that the meaning of ‘similar’ in this context would be a matter of judicial interpretation but that it might take account of the environmental, social and cultural characteristics of the child.

landscape for the work of expert witnesses in child proceedings. But few people could have envisaged the increased reliance of courts and local authorities on the expertise of health professionals (cf. Adcock, 1991, p. 12). Some clinicians (e.g. Bentovim, 1991*a,b*; Jones *et al*, 1991; Lau, 1991; Lynch, 1991)²⁰ did begin to address the concept of significant harm, and what constituted ‘abuse’, ‘normal’ development and ‘impairment’. In the context of discussing resources in general, Morrison (1991, p. 88) was somewhat prophetic in reviewing research on the treatment of ‘abusing parents’ and arguing that knowledge and research in this field would be essential for the future work of courts. He argued that “we will need to assess more quickly who is treatable”. But no writers, policy makers or clinicians addressed the question of demand relative to possible supply of clinical services for litigation purposes either before or shortly after implementation of the Act.

As the Children Act bedded in, two things were clear. First, the benchmark, set by the Children Act Advisory Committee (1991/2, p. 2) in its first *Annual Report*, of some 12 weeks for completing proceedings was quickly demonstrated to be totally unrealistic – even those cases that started and ended in the family proceedings courts and that did not involve any expert evidence did not meet this deadline (Bates & Brophy, 1996, table 31). Second, the demand for clinical assessments – especially from child psychiatrists – presented substantial problems not only of supply (Children Act Advisory Committee, 1993/4, pp. 14–15) but also, in some instances, of quality (Brophy & Bates, 1998).

The use of experts following the Children Act 1989

Two studies on the use of expert evidence in care and related proceedings provided the foundations for the study presented in this book (Bates & Brophy, 1996; Brophy *et al*, 1999*b*). These studies provided a range of findings about the use of experts generally (i.e. across all disciplines and by all parties) and about the use of local CAMHS in particular. For example, Brophy *et al* included a national random survey of cases involving expert evidence. The sample consisted of 557 cases concerning just under 1000 children. There were six major findings. First, reports from child psychiatrists formed the dominant type of expert evidence commissioned – these reports appeared in some 41% of all cases.²¹ Second, this was the major source

²⁰ In the early 1990s Lau (1991) was one of the few child psychiatrists to consider the concept of significant harm with specific regard to Black and other ethnic minority groups in Britain (cf. Maitra, 1995, 1996).

12 *Child psychiatry and child protection litigation*

of evidence commissioned by the professional parties (i.e. the local authority and the guardian ad litem). Third, parents were much less likely to file reports from child psychiatrists and more likely to file reports from adult psychiatrists.²² Fourth, it was very unusual for 'medical' evidence, that is, evidence from paediatricians, paediatric radiologists and so on, to be the only evidence in cases (under 11% of cases); rather, this evidence was generally followed by evidence commissioned from child psychiatrists.²³ Fifth, most child psychiatrists undertaking assessments for litigation purposes were working alone: 41% of cases contained reports from a single clinician, while only 15% contained a multi-disciplinary report. Finally – and contrary to much received wisdom at the time – most cases in the survey did not contain expert evidence filed by all three major parties in the proceedings: only 18% of cases fell into this category (Brophy *et al*, 1999*b*, figure 4.1).

The national survey also explored guardians' views on and use of 'locally' based CAMHS, the problems they were encountering, the improvements they wished to see in services and the criteria they applied in selecting a child psychiatrist. Relatively few guardians were satisfied with locally based CAMHS in so far as these services were able/willing to provide assessments and reports for courts – no guardian was unreservedly satisfied, while only 19% said they were mostly satisfied with services.²⁴ Of those who expressed dissatisfaction:

- (a) 72% were critical of local services because they lacked resources or a commitment to undertake further therapeutic work with children if that was deemed necessary;

²¹ This compares with paediatric reports filed in 35% of all cases; psychiatric reports on parent(s) filed in 32%; and psychological reports on parents and children filed in 12% (Brophy *et al*, 1999*b*, table 4.9).

²² Where parents were the only party to file any expert evidence in cases, psychiatric reports based on *adults only* appeared in over half (54%). Where parents were one of a number of parties to file any evidence, adult psychiatric reports appeared in 33% of cases. In contrast, parents filed *child and family* psychiatric reports in 12% and 15% of cases respectively (Brophy *et al*, 1999*b*, table 4.9).

²³ This is not of course to suggest that psychiatrists are not medically trained but rather to differentiate the disciplines that may be commissioned in proceedings. These disciplines and specialist fields are outlined in detail by Brophy *et al* (1999*b*, table 4.9).

²⁴ The response rate for the national survey of guardians was 71%; 31% of respondents were not satisfied with the service provided by the local CAMHS, and 50% said it was variable and depended on the area (Brophy *et al*, 1999*b*, p. 12).

- (b) 63% were also critical of local services because they lacked staff with sufficient training and experience to undertake instructions in public law proceedings;
- (c) 59% were critical of local services because of delays in getting reports.

In other words, the major sources of complaint were generated by the lack of a comprehensive service for children who are abused, neglected or otherwise maltreated by parents.

Among the improvements that guardians wished to see from the CAMHS were more locally based services able to work in this field and offer ongoing help to children, more resources and more staff trained and experienced in public law work, and an increase in the availability of multi-disciplinary teams able to offer a range of skills and expertise. Interestingly, while guardians were critical of many local CAMHS, they tended to be satisfied with the experts they themselves instructed: 88% were satisfied with the experts they used. The reason for most of the discrepancy (between assessments of local CAMHS and the clinicians instructed by guardians) was that, in certain sectors of the country at least, guardians tended not to use local services but rather tried to instruct a relatively small cadre of experts who were willing to work on a national basis.²⁵

Moreover, the findings also demonstrated that, in selecting an expert, guardians have two priorities. First, they require a clinician with a particular understanding of and sympathy with the needs of children *and* families involved in public law proceedings – not all clinicians were seen as ‘user-friendly’ in this regard. Second, clinicians must have previous experience as an expert witness and this included being skilled in the witness box and able to withstand cross-examination. In other words, the ‘tried and trusted’ expert dominated appointments. But guardians were also aware of the range of difficulties for child psychiatrists. They were aware of the anxieties that court work can provoke in untrained and inexperienced clinicians and of the reluctance of some therefore to get involved in cases. As Table 10 (p. 102) shows, some clinicians have posed a lack of time and general work overload as reasons for not undertaking instructions, some saw a conflict of interests between their clinical work and court work, but others expressed an unwillingness to be ‘grilled’ in court or to expose their work to criticism (Brophy *et al.*, 1999*b*, p. 16).

²⁵ That is, clinicians who did not restrict instructions to a geographical area but who were willing to accept instruction on a national basis.

14 *Child psychiatry and child protection litigation*

This, then, was the new and dynamic landscape for expert witnesses instructed in public law under the Children Act in the 1990s. 'Law' (case law, reports and practice directions from the Children Act Advisory Committee) increasingly attempted to control and regulate the agenda for the use of experts by setting out the duties and responsibilities for advocates instructing experts, for courts when giving parties leave (i.e. permission) to instruct experts and for experts themselves when undertaking assessments within legal proceedings.²⁶ Advocates were instructed to consider whether a joint appointment of one expert might be achievable, whether expert evidence in any given category could be adduced by one party, and whether and why experts in the same discipline needed to be instructed by more than one party. When seeking leave to appoint an expert, advocates were also instructed to provide the court with full information on the category of expert required, the focus of the assessment, the need for the evidence and the relevance of expert evidence to the issues under discussion.

In theory at least, the days of 'here are the papers, tell us what you think' were over. When writing the letter of instruction, advocates were told to set out the context in which the opinion was requested and to define specific questions to be addressed by the expert. The loss of litigation privilege in Children Act cases means that whatever the content of the resulting report, this now has to be disclosed to other parties and to the court. Advocates were also told to disclose the letter of instruction to other parties and to include it in the bundle of documents submitted to the court. In granting leave for expert evidence, courts were instructed there should be no 'blanket' leave for paper opinions, that they should routinely enquire into the category of expert required, the relevance of the evidence requested, whether a joint instruction was possible and whether one party only (particularly the guardian ad litem) could commission the expert, and, when granting leave for a second opinion, that they should enquire why there was a need for more than one expert of the same discipline. In addition, courts were instructed to give directions as to the timescale in which the evidence should be produced,²⁷ the disclosure of resultant

²⁶ For example, early case law – particularly *Re R (A Minor) (Expert's Evidence)* [1991] 1 FLR 291; *Re J (Child Abuse: Expert Evidence)* [1991] FCR 193; *Re AB (Child Abuse: Expert Witnesses)* [1994] 1 FLR 181; *Re G (Minors) (Expert Witnesses)* [1994] 2 FLR 291) – practice directions (The President's Practice Direction on Case Management [1995] 1 FLR 456), and the Children Act Advisory Committee (1991/2, 1992/3, 1993/4, 1994/5, 1995/6, 1996/7, 1997), as well as Booth (1996) all sought to modify and improve practices in this field.

²⁷ Or if, at the time of granting leave, that was impractical, to set a date for those directions to be given.

reports to other parties and, if there was a conflict of expert opinion, the discussions that should take place between experts and the filing of a statement identifying areas of agreement and disagreement.

Experts in turn were instructed not to be partisan, to provide a straightforward and not misleading opinion and not to mislead by omission; reports should be properly researched (indicating areas of insufficient data) and should clearly state if the report is provisional. Also, experts were instructed to maintain accuracy in the dating of reports and to stick to the brief given by the court.

This was the new terrain that was being carved, in effect a new interface between 'law' and the work of child welfare specialists. New research (e.g. Bates & Brophy, 1996; Brophy *et al.*, 1999*b*; Hunt & Macleod, 1998) and case law following the Children Act 1989 demonstrated the interdisciplinary nature of proceedings and the central role of child psychiatrists in that development. But the perspective of experts themselves was missing. Contemporary debate raised questions about their work and the value of their contributions, but few contributors questioned what it might be like to be 'on the receiving end' of a very much more prescriptive but rapidly changing legal agenda. Equally, the lack of policy initiatives on the part of central government to deal with the supply if not the training aspects of CAMHS provision during the 1990s was striking. Chapters 2–5 therefore aim to demonstrate how experts themselves responded to the issues and challenges posed by allegations of child abuse/neglect within the framework posed by Children Act proceedings.