JANUARY 2021

I am back in action.

I attach an updated set of reported cases. The additions start at p. 32.

Those of you who are EWI members have probably seen the judgment in *Neurim*. I've set out the detail of the judge's criticisms of the expert. The message is short and simple. If you have to assess capacity to engage in auto-erotic asphyxia, there's now a case to guide you. For those of you in C&A there is a helpful case on assessment of a child's litigation capacity. There's a helpful case concerning opinions on what I call clinical plausibility. And I have finished with today's judgment in the Assange case, obviously of general interest, but useful in terms of a close examination of how the court approaches contested expert psychiatric evidence and the court's approach to capacity to commit suicide in the context of extradition cases. But it sounds as though the US Government may appeal so watch this space.

FEBRUARY 2021

Judgments

Since I last emailed you, there have not been many judgments to bring to your attention but the four new ones are each important in their own way. If you have read the ones previously circulated, start reading at *Z v University Hospitals Plymouth NHS Trust*.

Z is important simply as a case of 'how not to do it'. The expert's errors were fairly gross. What is interesting is that he had no written instructions. I doubt that expert psychiatric witnesses are ever in that situation but I suppose it could happen in an emergency capacity case involving life and death decisions. But it will occasionally be the case that some oral instructions are given, often after the initial written instructions, and the expert is under a duty to set out their material substance in their report. It is also an important judgment because it reminds us that where we rely for evidence on information from other people, there must be a record of the conversation.

R v Dunleavy will be mainly of interest to those of you who work in the criminal jurisdiction. It is yet another judgment that concerns a defendant with an autistic spectrum disorder and again illustrates how the court needs assistance as to how the psychopathology relates to the criminal behaviour. The white paper on reform of the Mental Health Act is now raising further the issues of how society should respond to difficulties that people with autistic spectrum disorder and there are radical proposals about the application of Part II to people with autistic spectrum disorder. But people with autistic spectrum disorder who are convicted (or found unfit to plead and stand trial) will still fall to be considered for assessment or treatment under Part III and I think that as public, and professional (i.e. legal) awareness of autistic spectrum disorder increases, there will be greater expectations of the psychiatrists who assess people with autistic spectrum disorder whose behaviour causes them to be caught up in police and criminal justice processes.

AMDC has been back in court. Read this if only to see what expert psychiatric witnesses can expect in terms of judicial praise if they do their job properly.

Devon may have implications if in criminal case you have recommended, or intend to recommend, orders under Part III of the Act, or have given an opinion that someone is unfit to plead and stand trial, based on remote consultations rather than visiting and examining the defendant in person.

Reflections on the Annual Report of the Forensic Science Regulator - Dr Gillian Tully CBE 13 January 2021 https://www.gov.uk/government/publications/forensic-science-regulator-annual-report-2020

Of course psychiatrists are not forensic scientists but if eventually there is some form of required accreditation or registration of expert witness, it is probably a good idea to keep an eye on what regulation means for those expert witnesses who are closer to being statutorily registered than we are. I recall watching anxiously as the Council for the Registration of Forensic Practitioners eyed up forensic pathologists, asking myself if it would then turn its attention to forensic psychiatrists, but then the Council went into extinction. However, legislation (https://bills.parliament.uk/bills/2616) is making its way through Parliament which, if enacted, will provide statutory enforcement powers for the next Regulator (now that Gillian Tully retires with her CBE). It will also mean that those who fail to follow robust scientific methodology and the legal requirements on experts can be prevented from continuing to pose a risk to the criminal justice system (the CJS).

In what is now her last annual report, Dr Tully has stated that the aim throughout her tenure has been that all forensic science and forensic pathology provided to the CJS in England and Wales is of the required level of quality. She has observed that despite the CrimPR requirement for expert witnesses to disclose information which may undermine their credibility to the party that instructed them, experts who have been repeatedly, and seriously, criticised by the courts and experts who have failed to meet the required quality standards continue to be instructed in a substantial number of cases. Insofar as expert psychiatric witnesses endeavour to apply scientific methodology it could be argued that the quality of expert psychiatric evidence should be judged by standards applicable to forensic science in general. Of course it can be, and is in Canada, argued that expert psychiatric evidence is not scientific evidence but belongs with evidence from the 'soft' or 'behavioural' sciences and should be treated different in the justice systems.

With these thoughts in mind, I decided to look at the bill to which she has referred – the Forensic Science Regulator Bill. This bill, if enacted (I think it is at committee stage), will create a duty on the Regulator to prepare and publish a code of practice about the carrying on of forensic science activities in England and Wales. Clause 11 states that 'In this Act "forensic science activity" means an activity relating to the application of scientific methods for a purpose mentioned in subsection (2)' and subsection (2) states that 'Those purposes are— (a) purposes relating to the detection or investigation of crime in England and Wales; (b) purposes relating to the preparation, analysis or presentation of evidence in criminal proceedings in England and Wales; (c) such other purposes as the Secretary of State may specify in regulations made by statutory instrument.' It appears to me that if, as psychiatrists, we apply scientific methods in our psychiatric investigation of the issues about which we assist the courts for the purpose of preparing, analysing or presenting evidence in criminal proceedings, we are engaged in a forensic science activity and will fall to be regulated under this Act. If we want psychiatric evidence to be recognised as reliable because its 'subject matter […] is within a recognised scientific discipline' (*Kennedy v Cordia (Services) LLP* [2016] UKSC 6) then we may find ourselves falling to be regulated under this Act.

Working Group on Medical Experts in the Family Courts Final Report https://www.judiciary.uk/publications/the-president-of-the-family-division-working-group-on-medical-experts-in-the-family-courts-final-report/

This report by Mr Justice Williams is dated October 2020 and was published on 5 November 2020. The working group was set up to address a problem of a "paucity of medical expert witnesses in family cases involving children" and one of the shortage groups identified was "child and family

psychiatrists". The working group had representatives from the medical royal colleges with several from the RCPCH but no representative from the RCPsych or the FFLM. However, the BMA had two representatives including Jan Wise who is a psychiatrist and active as an expert witness. The working group carried out a survey at an early stage and a consultation on its draft recommendations more recently but I was not aware of either. I do not know to what extent, if at all, the RCPsych was involved. However, the working group was satisfied that it did reach an appropriate cross-section of experts. Nevertheless, I note that the survey was targeted to health professionals working within the field of paediatrics and child health. I note that the RCPsych and the EWI are not listed as bodies to whose members it was distributed although it was distributed through the Consortium of Expert Witnesses and if this is Judith Freedman's organisation this is probably how it will have reached some psychiatrists. Psychiatrists made up 20% of the respondents.

Some of the findings and recommendations require discussion and action on the part of bodies and groups such as the Royal College of Psychiatrists, the Faculty of Forensic and Legal Medicine, the Grange Conference Trustees, the Expert Witness Institute and ETN. I refer to some of these here but do recommend reading the whole report.

A reference in para. 17 to "disincentives to senior registrars [*sic*] or consultants considering taking on expert work" is a clear indication that there is an expectation, at least in the family courts, that specialist registrars will undertake expert witness work. I suggest that this means that higher training in child and family psychiatry should include the acquisition of competencies similar to those that the RCPsych expects that higher trainees in forensic psychiatry will acquire (see p. 45 in *Rix's Expert Psychiatric Evidence* (2nd edition), CUP, 2021)). The barriers or disincentives identified include 'lack of support and training' (para. 18c) and 'perceived criticism by lawyers, judiciary and the press' (para. 18.d).

The first of the 22 recommendations is:

> "Action by the Royal Colleges/Professional bodies to create online resources to support expert witness work and to increase awareness of existing training in the field provided by organisations such as the Academy of Experts and the Expert Witness Institute" (para. 22a).

The second and third recommendations are:

> "Encouragement to the Royal Colleges/Professional bodies to engage with commissioners and or trusts to promote a more supportive environment to medical professionals … who wish to undertake expert witness work" (para. 22b).
>
> "The Royal Colleges … and the FJC (Family Justice Council) to engage with NHS England and clinical commissioning groups to seek changes to contracting arrangements to enable healthcare professionals to undertake expert witness work within the parameters of their employment contracts."

This strikes me as a tall order for the RCPsych given the number of commissioning bodies and trusts but perhaps not so if there are overarching bodies with which to liaise at a national level. When I discuss with consultants and trainees the importance of trainees being trained in expert witness work during higher training when formal supervision is available I often hear that trusts do not allow trainees, and even in some cases consultants, to undertake expert witness work. I have often said that those trusts should not be surprised if their defence of clinical negligence actions is more complicated, expensive and protracted because they cannot get independent experts with sufficient experience of the NHS and because claimants' solicitors rely on expert evidence from doctors who

work outside the NHS and do not have sufficient or sufficiently recent experience of the NHS. There is an ethical obligation laid on doctors to assist in the administration of justice and providing expert evidence to courts and tribunals is a public service. Commissioners and NHS trusts must not be allowed to interfere with the discharge of this obligation and the provision of this public service.

There are two recommendations relating to payment and remuneration (paras. 22d, 22e) and those of you who report for the family courts will probably be aware of the fact that the Legal Aid Agency has already made some of the recommended changes, these being set out in revised Guidance on the Remuneration of Expert Witnesses - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925207/Guidance_on_the_Remuneration_of_Expert_Witnessesv6.pdf.

There is a recommendation about more efficient instruction and a unified point of contact communication (para. 22g).

There is a recommendation about a more efficient approach to timetabling of oral testimony (para. 22h).

Recommendation i is for more appropriate treatment of experts during hearings, within judgments and thereafter with support for constructive engagement and feedback (para. 22i).

It is recommended that the FJC should create a subcommittee to support and maintain the implementation of the recommendations by a programme of ongoing liaison with other stakeholders including the Royal Colleges and training organisations (para. 22j). I have been invited to join this subcommittee and intend to accept the invitation.

Recommendation l is:

> "Create greater training opportunities for medical professionals … including mini pupillages with judges, cross-disciplinary training courses with medical and legal professionals, and mentoring, peer review and feedback opportunities" (para. 22l).

I can point out that the chapter 'Training, development and the maintenance of expertise' in *Rix's Expert Psychiatric Evidence* covers all of these at least to some extent. I use the term 'judge's marshal' rather than mini-pupillage. I do not specifically refer to cross-disciplinary training but I do refer to the function of medico-legal societies, many of which provide cross-disciplinary training. Although there is a reference in the report to mentoring, there is no reference to the significance of *Pinkus v Direct line Group* (EWHC QB, unreported, 2 January 2018).

Although there is no recommendation for a Centralised Register of Accredited Court Experts (para. 24) it is believed that this is a subject that should be considered further by FJC and reference is made to the EWI Directory of Expert Witnesses amongst others. I think that some form of accreditation for expert witnesses will come sooner or later and the sooner the RCPsych, FFLM and EWI (and perhaps the Academy of Medical Royal Colleges) get into a dialogue about this the better. Some sort of accreditation could come about through the Forensic Science Regulator Bill, if enacted (see above). If not properly developed, the courts could be flooded with well qualified medical specialists who are not properly trained as expert witnesses or the system could restrict access to those medical experts whose skills are needed by the courts and who are already in short supply.

The main barriers to provision of expert assistance to the courts were, in order of importance: financial, court processes, lack of training and support and perceived criticism (para. 39).

Paragraph 51 states that there was considerable demand for training on how to be an expert witness and how to give evidence in court. The survey also identified an "appetite for refresher and update courses, which would cover developments in the law and medical diagnoses". I observe that The Grange Annual Conference has been satisfying this appetite for almost twenty years. Likewise it caters for "less experienced professionals seeking to become expert witnesses and … existing expert witnesses wanting to upskill and maintain their knowledge".

The range of options for the delivery of training suggested by the respondents included peer review, discussion sessions and mentoring schemes (para. 51). The Grange has pioneered peer review of expert witness work and this has been carried forward at The Grange Annual Conference. The EWI has as mentoring scheme.

Sixty-two per cent of respondents did not feel supported by their Medical Royal College / Professional Association to complete expert witness work (para. 53). How many of these were psychiatrists is not stated. The RCPsych peer group system lends itself to the provision of support.

A number of respondents expressed reluctance to engage with expert witness work due to anxieties about unfair criticism by judges and in the media. These fears were greater in those who had not undertaken expert work (para. 55). The working group suggests "closer networks between the medical, psychological and legal professions, along with the judiciary" to possibly alleviate some of these concerns. It is not clear what this means.

Lawyers were also surveyed. They were asked if they had noted a decline in the quality of expert reports (para. 101). A decline in quality of reports by child / child and family psychologists topped the list and was reported by 33.7%. Next came paediatricians with a decline noted by 26.3%, then child / child and family psychiatrists 22.2% and adult psychiatrists 18.9%. With the exception of risk assessors (12.5%) percentages were in single figures for all other specialists. I do not think that I was a respondent to the survey but I am reminded that often in such surveys I take the opportunity to mention monkeys and peanuts. But seriously, this is a finding that underlines the challenges that the psychiatric profession faces if it is to play its proper role in the administration of family justice.

Judicial criticism and hostile cross-examination were identified by 35% of respondents as a reason for the shortage of expert witnesses (para. 106).

At paragraph 128 there is the following statement:

> 'The purpose and importance of giving such evidence needs to be emphasised to the Royal Colleges, NHS trusts and all the professional bodies and there should be a proper budget for such training."

There is a reference to the EWI at paragraph 129:

> 'There are organisations such as the Expert Witness Institute and the Academy of Experts, which provide accreditation, support and training. These do come at a cost for experts, however, and the difficulty is to persuade would-be experts to pay for this.'

But I would observe that reluctance to pay to join such bodies is unsurprising when the LAA rates of remuneration are so low that for many experts they do not cover their overheads and experts have to subsidise their LAA-funded expert work from properly paid expert witness work. This is acknowledged in paragraph 131.

The report discusses at some length in paragraph 146 the vexed issue of judicial criticism and it includes:

> 'In cases where a judge proposes to name and criticize an expert in their publicly available judgment and those criticisms have not been raised in evidence the expert should be entitled to be made aware of the criticism and comments on it or see a draft of the judgment in advance of publication and have the opportunity to make representations to the judge. The representations should include any concerns on the fairness of the comments and whether they should be named, prior to any publication taking place.'

At paragraph 148 there is reference to how the provision of the final judgment to the expert is considered to be a valuable form of feedback to the expert.

Several paragraphs address the issue of the volume of paperwork that is sent to experts (paras. 150 – 152) and there is a suggestion that in cases where not all documents are sent, the expert should be provided with an index and a specific direction to consider, within 14 days of receipt of instructions, whether further papers are required. Experts will be delighted to read that: 'All records and case papers must be paginated before they are sent to any expert.' I say that this should apply in all jurisdictions and in all cases and, where a multitude of bundles is provided electronically, there should be guidance which makes it clear how each and every page is to be referenced.

Many paragraphs are devoted to how implementation on the ground of the training recommendations could be achieved and it is suggested that the FJC subcommittee and regional groups would be responsible for:

- Setting up and delivering training to experts and lawyers (para. 183a)
- Setting up and delivering a medical mini-pupillage/Marshall's scheme (para. 183b)
- Promoting inter-disciplinary respect and cooperation through promoting feedback from judges and lawyers to experts and vice versa through mentoring and peer discussion of cases in an anonymous environment including possible "some form of formal channel for feedback including where concerns were expressed by a judge about a report or evidence given as an intermediate step rather than matters being referred directly to the GMC" (183c)

The RCPsych already offers its members a formal channel for feedback by instructing lawyers and judges, the 'Multi-source Assessment Tool for Expert Psychiatric Witnesses' (MAEP). Later in the report there is a recommendation at para. 201.3 for "A vehicle for feedback from the legal profession, in particular the judiciary to experts ranging from simple notification of the outcome of a case through to constructive criticism to aid professional development …" MAEP is a vehicle for feedback from the legal profession, including the judiciary.

There are a number of recommendations for the Medical Royal Colleges:

1. To create an online resource checklist for healthcare professionals which details what is expected from expert witnesses. For psychiatrists I would hope that this is contained in CR193 *Responsibilities of psychiatrists who provide expert opinion to courts and tribunals.* This is undergoing its delayed 2020 revision so I anticipate that the revision will have regard to the recommendations in this report.
2. Royal Colleges to increase awareness of existing training and further develop combined training courses between different specialties.
3. Improved collaborative working between Royal Colleges to ensure that issues pertaining to expert witnesses can be discussed collaboratively. Royal Colleges could consider appointing a lead clinician/ officer for expert witnesses.
4. RCPCH, RCR and other Medical Royal Colleges to engage with commissioners and / or Trusts / Health Boards to enable their members to have conversations with their employers and

encourage them to support expert witnesses to participate in this work. There is then a recommendation that the RCPCH and RCR should write to Medical Directors / Chief Executives of Trusts. I suggest that that the RCPsych should also be a signatory.

5. This is similar to 4 but the focus is NHS England and Clinical Commissioning Groups.

The medical royal colleges and faculties are beginning to respond to Recommendation 3. I have been appointed Expert Witness Lead for the FFLM, the Royal College of Radiologists and the Faculty of Emergency Medicine have appointed expert witness leads with whom I am already in touch and the RCPsych is taking advice from the Forensic Faculty.

Recommendation 17 at para. 202 is for barristers, solicitors and judges to be permitted to assist with training of expert witnesses in working time and for barristers and solicitors to be paid. For almost 20 years this has been happening at The Grange Annual Conference. The judges who have contributed have ranged from district judges to the vice-president and president of the Supreme Court. The Grange Annual Conference is a model that could be adopted by other medical specialties.

There is much in this report's recommendations which is applicable outside the family jurisdiction and it may only be a matter of time before some of its recommendations are applied in those jurisdictions.

We have invited Sir David Williams to speak at this year's Grange Conference.

Chris Pamplin has noted that many of these recommendations are not new. I share his hope that they will not gather dust.

MARCH 2021

APRIL 2021

This is a long email but you do get to 'Fifty Shades of Grey' at the end.

Recent judgments

The most recent judgments begin with *R v Rebelo* which illustrates what happens when the court changes the legal test part of the way through the expert's evidence and how much of a disadvantage the expert is who is brought in during the trial and expected to produce their report in a hurry over the weekend with limited information. *R v Murphy* is another case concerning the admissibility of expert opinion as to credibility and truthfulness and in this case related to the defendant's IQ. *PCP* is the usual case that contrasts two experts, one demonstrating how to give evidence and the demonstrating how not to give evidence. *A Local Authority v Mother* illustrates how experts will be complimented for doing the job properly. *Louis v Home Office* illustrates the value of having worked in a custody setting if giving evidence where the issues are false imprisonment and unlawful immigration detention. *Fletcher v India* is helpful as it illustrates how careful consideration of impulsivity can assist in extradition cases where suicide risk is the issue. *Gardiner* is of interest as it is unusually a case where hypomanic symptomatology had to be taken into account in relation to testamentary capacity. *Negus* concerns the nature and recency of relevant experience and also the important of not misleading by omission when quoting the literature. *R v Lall* is another hybrid order case, this one illustrating the importance of establishing

why the defendant did not take their medication. *Kwikbolt* illustrates the risks associated with succumbing to pressure from the instructing legal team but whether the experts realised this is not clear. *Towuaghantse* and *Bux* are two quite different GMC conflict of interest cases, the former illustrating how potential conflicts of interest do not prevent an expert's evidence being admitted as independent and unbiased and the latter where a medical expert running an expert witness business on an industrial scale was unsuccessful in appealing erasure by the MPT; it was not just that he had a conflict of interest but he was dishonest and wrote formulaic reports with a disregard for the Civil Procedure Rules and the Guidance for the Instruction of Experts.

Family Justice Council seminar

I was pleased to 'see' at least two of you at the FJC seminar last week. It was intended to move forward with the recommendations of the working group chaired by Mr Justice David Williams. I think that some of the 'chat' suggested that some of those present felt that people were just dwelling on the problems and that nothing was changing. Certainly many of the questions as well as the points covered in the panel discussion were ones which I have heard aired many times over the years at meetings, whether in the formality of the panel discussion or informally over coffee. However, the event was very much over-subscribed and there is undoubtedly enthusiasm to make changes and move forwards.

I will keep you posted. I have been co-opted onto the FJC subcommittee which David Williams chairs. I have also been appointed expert co-chair with HHJ Jaron Lewis of the Regional Expert Group for the East of England. This corresponds to that part of the South East Circuit north of and outside London, i.e. Cambridgeshire, Norfolk, Suffolk, Essex, Bedfordshire, Northamptonshire, Hertfordshire and perhaps more. I know that at least one of you has expressed an interest in joining the regional committee so more on that next month.

Although this is an England and Wales FJC initiative, it provides the opportunity to do much that will improve the provision of expert evidence not only in the other jurisdictions within England and Wales but throughout the UK.

Parole Board reports

I received a query which is worth sharing with you. I was able to refer it to Huw Stone and I am grateful to Huw for his response and for providing the attached 'In-Reach Paper'. Here is the email I received with my comments embedded in red and below it is Huw's response.

I am working in NHS prison mental health and my colleagues (Psychiatrists and RMNs) and I have started to get requests from the Parole Board to provide reports on our prison patients

These have sometimes been accompanied with an indication that a subpoena could be issued to enforce attendance at a Hearing The Parole Board has the power to obtain a witness summons and I assume that this could be in order to ensure either the attendance of a witness to give evidence or for them to produce particular documents that are required as evidence. Without the exact wording (and if 'subpoena' is used this is puzzling, as this is not current terminology) I am not sure what this means. However, it seems to me that if the PB decides that a particular person can provide evidence which will assist and which it is necessary to receive and / or that person can provide a document which will assist and which it is necessary to receive, then the PB can issue a witness summons to achieve that end. What the PB may, and probably does, need is a report from a, or a specified, health professional. I think you sense this as a sort of threat: if you don't produce the report, we will order your attendance and then you can explain to the PB why there is no report. I hope that it was

not so intended but if that is your perception, and the reasonable perception of anyone else reading it, then it seems that it could be more helpfully written.

But if you are issued with a witness summons either to attend or to produce a document you could be found in contempt if you do not comply. On the other hand a witness summons cannot be used to compel someone to provide expert opinion and I make this point because it raises the issue of what the evidence is that is sought in a report requested of you by the PB.

I have a number of concerns, mainly that there could be a conflict of interest, At first glance there would appear to be a conflict of interest and it is between the ethical principles of 'non-maleficence' and 'justice' but as you drill down I am not so sure that there is. I think that you are being asked to provide the factual information which will enable the PB to do its job which is to make a just and fair decision about the liberty or otherwise of your patient having regard also to public safety etc and the PB is an expert tribunal so it will use its inherent expertise to decide the ultimate issue (release, transfer to a lower category of prison etc) and your report is providing the part of the matrix of facts which will inform that decision. Even if it cannot be argued that 'justice' trumps (I now have trouble with this word) 'non-maleficence', you may think that it is not in your patient's interests to disclose information (e.g. non-compliance with prescribed medication, lack of insight, etc) which would weigh against the decision to release or transfer to a lower category prison) it could be argued that withholding that information could be setting up your patient to fail. So I think that your conflict of interest point is more apparent than real. but also that staff might be pulled into dealing with matters outwith their expertise, I sense here that your concern is that you and / or other health professionals are being asked to provide expert opinions that you are not qualified by training or experience to provide. This may be your misunderstanding of what is being asked of you. It is a matter of fact that the prisoner had received several different psychotic diagnoses before imprisonment but has been consistently diagnosed throughout their sentence as having paranoid schizophrenia. You are simply stating this as a matter of fact and enabling the medical member to tell the other PB members, that this prisoner has schizophrenia. That is not expert opinion. He has or has not got schizophrenia, matter of fact. You are saving the medical member the trouble of reading through pre-conviction hospital and general practitioner records and volumes of prison medical records. But there may be a misunderstanding on the part of those seeking the report, but even if not, and you are asked something that calls for an opinion which you are not qualified to give, you simply state that the question/issue is one for which you do not have the qualifications, training or experience to answer but I do not think that the PB is asking for expert opinion because, if it needs expert opinion, it will go to independent experts and that prison mental health services are not commissioned to provide these reports they may or may not be commissioned to do so. When I started as a prison visiting psychiatrist, first as an hon SR in Strangeways with Angus Campbell and then in 1983 as a consultant in Armley we produced reports according to 'custom and practice' for the prosecution in all murder cases and they were meant to be produced for some other serious offences, such as rape, but in practice, probably simply on the basis of the volume of reports, we only produced them for murder cases and they were always paired with a report from a prison medical officer. But I never saw any sort of contract or commissioning document or even Home Office circular that established this practice. No doubt today commissioning results in detailed contracts specifying what a prison inreach mental health team should do. You may or may not find PB reports specified in those contracts but if they are not that is probably an oversight because there is no one better able to produce a psychiatric report on a prisoner for their PB hearing than the psychiatrist who has been involved in their care. They could be provided by one who has not been involved but they will probably take longer as they will not have a memory of incidents in their medical history and not be able to go so quickly to documents or entries in the records which will inform the content of the report.

These reports would also take considerable time, when the focus for in-reach teams is on treatment There are several responses to this. One is that if the teams are to provide the reports, the teams need to be resourced to allow them to do what is inevitably time consuming. Another answer is that treatment may mean rehabilitation and rehab may mean judging accurately the right time to step down to a lower level of security.

I thought that Parole Reports are usually commissioned independently, but I personally do not undertake independent reports for Parole The PB like any specialist tribunal can admit expert evidence of opinion and it is likely that this will be commissioned independently but this is not to be confused with a report from those who have the care (and knowledge) of the prisoner and are the de facto custodians of huge volumes of records and reports.

What I wanted to ask is..

1 Are NHS / treating staff obliged to produce such reports? I think there maybe two ways of answering. It depends on the contract and if it is not in the contract I suppose that there is no contractual obligation to do so. But on moral/ethical grounds yes.

2 Would there be a conflict of interest? Probably not. See above.

3 Does the Parole Board have the authority to subpoena treating clinicians to appear? Yes. See above.

Huw's response:

Your email is very interesting and quite timely as 2 psychiatrist Parole Board colleagues and I are currently trying to do some work to help address the issues that you raise concerning the relationship between MH teams both inside and outside prison and the Parole Board. One of my colleagues, Dr John O'Grady has written the attached paper at the request of Dr Steffan Davies specifically to help teams such as yours with their interaction with the Parole Board. I think that you will see that it actually answers the questions that you raise in your email. You are very welcome to forward the paper to your colleagues.

One thing that I would like to emphasise is the statement at the beginning of the paper that this is the opinion of one psychiatrist member of the Board and cannot be taken as official Parole Board guidance.

I am not personally aware of any subpoena to attend hearings, however, as the paper states, there is a prison rule that requires healthcare staff to cooperate with the Parole Board in providing reports, so, if a member of healthcare refuses to provide a directed report, the healthcare manager could be asked to attend a hearing to explain why. However, we would always hope that healthcare staff, including MH teams would be able to help the Parole Board with their requests, so that this situation is not reached. Also, in my experience, it is not always the case that a report writer has to attend the subsequent oral hearing. Very often, I have found that if the report addresses the issues that the Parole Board needs to know, then the person who wrote the report is not required to attend. An oral hearing is not like a court hearing under the adversarial legal system, it much more like a Tribunal. If a report provides information, then it is accepted. The only reason someone has to attend is if the report doesn't provide the information. That is why the section on

page 4 headed "*What does the parole board expect from professional reports from in reach teams?*" would be helpful to you and your colleagues.

Lastly, it is worth remembering that, in the case of doctors, the GMC does require them to cooperate with legal hearings involving their patients, this is not meant as a threat or compulsion, but just shows the importance that regulators such as the GMC places on doctors to work with legal bodies such as the Parole Board.

I hope that you and your colleagues find this information helpful.

Fitness to plead and stand trial query

This one rather took me by surprise and that may come across in my response which follows.

I gave evidence yesterday at the Old Bailey on a fitness to plead matter.

Given the gravity of the situation, i carefully read your advice as given in Expert psychiatric evidence 2nd Ed, and quoted the FTP test as operationalised in R v M John 2003 to justify my findings.

I was challenged on this. The prosecuting QC stated that the judges explanation in John were of "no significance" and that applying this to the current case is an "error of law".

My reply at the time was that I understood that FTP is case specific and that i had used the judges explanation as a framework to address each arm of Pritchard and that my opinion was based on the findings as a whole.

The second issue that they took umbrage with, was that i gave more weight on my findings at interview (he was fairly able) and less so on the concerns expressed by counsel on capacity to instruct meaningfully. The question was framed as "we have 150 years of legal experience between us which was trumped by your 90 min interview"

I suppose my query is 2 fold,

Is it the case that we cannot generalise the judges explanation in John?

My second query is that isnt there merit in the argument that a solicitor/counsel is best placed to make a judgement on effective participation? (not withstanding their bias of course)

My response:

This is quite fascinating.

I suspect there is an element of ‘what the judge/counsel had for breakfast’ which is a variation on which side of the bed they got out.

I am copying this to Nick Hallett as we have just written a chapter for a forensic medicine textbook on FTP and, not surprisingly, relied on *R v M (John)*. I find the position they took in your case difficult to understand and to reassure myself about the singular position of this case I have just taken my

2021 *Blackstone* from the shelf and under 'Test of Unfitness to Plead', after setting out Pritchard in full:

> The elements of this test were helpfully enunciated in directions that the Court of Appeal approved in *M* [2003] EWCA Crim 3452. The following points emerge from the modern application of Alderson B's direction in *Pritchard*:

Then the rest of the page is taken up with 6 points all derived from the case.

I find it difficult to see how you can be accused of an 'error of law'. If for some legal reason *M* and / or *Pritchard* did not apply, well that is for the court to decide. We often read about cases being fact specific or turning on their facts and perhaps this was a case in which there was something about it which meant that *M* and / or *Pritchard* did not apply but how were you to know. I suppose in the future, when dealing with FTP, in negotiating instructions we would be advised to ask 'Do you want me to apply the *Pritchard* criteria (as it were unvarnished) or the *Pritchard* criteria as enunciated in the directions that the Court of Appeal approved in *R v M* [2003] EWCA Crim 3452?' being careful to miss out the word 'helpfully' from the *Blackstone* quote.

There must have been something highly unusual about the case (or counsel) for *M* to be set aside in the way that it was.

The second question is more difficult. It is reasonable to use the psychiatric consultation to reach a conclusion about ability to give instructions and follow the course of the proceedings but for both the proof of the pudding is in the eating as they say and if instructed by the defence, which can include written or oral instructions as to the difficulties that solicitor or counsel has had in taking instructions from D, which usually includes of course commenting on the evidence that will be given at the trial (i.e. following the course of the proceedings), it is reasonable to give greater weight to the difficulties they have had than to the relative ease with which you have elicited what will essentially be their instructions and their understanding of the evidence. I think that this applies even more so to giving evidence as for most people there will be a big difference between telling you what happened in the relative comfort of your consulting room and telling the court and the public in the witness box.

I think that when they get down to 150 years v 90 minutes you know you're on a losing wicket and all you can do is be deferential, be courteous and don't get into an argument. Specifically defer to their greater experience. (If they have got all that experience why have they asked for yours?!)

***

This query has something in common with another, which I cannot disclose in full as the case is ongoing, but it raised an issue as to how to frame an opinion where at the point you assess the person they would be unfit to plead and stand trial but with special measures/intermediary they would be. It prompted me to respond:

We perhaps need to think more carefully about how we express opinions. If someone is capable of following the proceedings if they have an intermediary does this mean that they are/are not fit to plead and stand trial. They are unfit unless and until they have the intermediary.

Special measures have altered the landscape in relation to fitness to plead and stand trial. I would be interested to hear from others as to issues that may have arisen and as to how they express opinions in such cases.

Criminal Legal Aid consultation

I have only just seen this and have not read it:

Independent review of criminal legal aid: Call for Evidence

This may or may not be an opportunity to raise the issue of how the Legal Aid rates for expert reports are insufficient for most experts, at least for those who pay to meet compliance and indemnity requirements, to cover their overheads.

Fifty shades of grey

I had prepared a report that was submitted in advance of the date for disclosure. At 00.03 hours on the day of the next hearing, I got an email from counsel asking for my availability for a trial date in June and saying that he needed the information by 09.45 hours. At 00.57 hours there was an email from the CPS lawyer in the case:

a) The report uses different font colours and types (some are just straight lifts from the defence report). There should be uniformity throughout so please could this be updated.

It was of course remiss of me not to convert these quotes and pastes to Arial 11 and not to have noticed that they were in a shade of grey just subtly different from the default black of Word. And being the dutiful expert that I am, the amended report was with lawyers for 9.45 a.m. but I was not aware of any official guidance on font, font size and font colour, so I have asked for it (and not had a reply so far). It was before I wrote the first ediition of EPE that my solicitor daughter told me that Arial 11 was the mandated font for court documents but I have never seen chapter and verse.

PRACTICE DIRECTION 27A – FAMILY PROCEEDINGS: COURT BUNDLES (UNIVERSAL PRACTICE TO BE APPLIED IN THE HIGH COURT AND FAMILY COURT) states:

5.2 All documents in the bundle (including statements, affidavits, care plans and experts' reports and other reports) shall (a) in the case of a paper bundle be copied on one side of paper only, unless the court has specifically directed otherwise, (b) be divided by the author into numbered paragraphs and (c) be typed or printed in a font no smaller than 12 point and with 1 ½ or double spacing.

Having been prompted to research this, I have now found that for bundles uploaded for the Court of Appeal in cases under the CPR PD 52C states: Page numbering must not reduce the font size of any document below 12 points.

I would be interested to hear from any of you who have had similar requests and from any of you who know of sources of guidance/regulation on this point other than in FPR. In the meantime I will continue to use Arial 11. However, it will not be long before an insomniac lawyer notices at 1 a.m. that I have not used 12 point and then my practice may change. I would like to think that by using 11 point instead of 12 and 1 ½ spacing instead of double spacing I am saving trees in the rain forests and reducing environmental damage but send me down that line of enquiry and I will have to find out about the difference the length of the attachment makes to the CO_2 emission of the email under cover of which it is sent!

MAY 2021

Redacted medical records

One of you recently wrote:

> One of my biggest problems now as an expert in the [Family Court] is that GPs and Trusts redact notes when asked to supply them for legal purposes; sometimes to the point of incomprehensibility. Obviously they are being disclosed with the client's consent. I think this is wrong; and actually gets in the way of providing good quality evidence to the family courts. What do you think?

This was my reply:

> You do not know what has been missed out.
>
> For me it is a sore point. I was 2 ½ years under investigation by the GMC and one of the complaints was that I had misled the court by not referring to the contents of some social services records. The investigators eventually confirmed what I told the GMC, which was that these were records which the judge said were not to be disclosed to me! The complaint was eventually thrown out when the GMC's own expert got to the bottom of the case and said that my only mistake was not providing the complainant with the opinion for which he thought that he was paying, i.e. by refusing to be a hired gun I had prompted his complaint.
>
> Where there are redactions I have a standard sentence to the effect that I cannot be held responsible for any error of opinion that results from not having access to the complete and unredacted medical records.
>
> I have an ongoing criminal case where the notes are heavily redacted. The solicitor has applied for a court order to be served on the general practitioner ordering disclosure of the unredacted records.
>
> The problem is that this is not covered with any specificity or particularity in the DPA or GDPR. In a previous criminal case the QC said that an expert should be trusted with the unredacted records and I was then provided with them unredacted.
>
> Some redacting is bizarre: hospital postcodes, the name of the general practitioner surgery, names of some but not all consultants in a particular department.

This is how I dealt with this in a recent report:

> 1.1.1. The copies of the Defendant's medical records have been redacted in places. It may seem obvious but I cannot be held responsible for any error of opinion resulting from a failure to take into account information that has been withheld from me. I make this point because this was once the basis of a complaint about me to the General Medical Council and which complaint it took over two years to dismiss.

I would be interested to hear how you all deal with redacted records. I hope I can share the information next month.

Recent judgments (most recently added are *Barrow v Merrett* from p. 132 onwards)

There have been only five recent judgments which I think it worth bringing to your attention. Interestingly three of them deal with the issue of a change of expert opinion.

In fact *Crosby v Wakefield MBC* is not recent. It is just that I have only recently discovered it. I am not sure how I got there but it is an unpublished judgment to which a barrister, Gordon Exall, drew attention on his chambers' website. It is really quite shocking. Neither of the orthopaedic experts escaped criticism. But one of them was criticised for a number of failings: not being thorough enough in reviewing the medical records, not including a range of opinion, even though he had been criticised for this previously, and seemingly withholding that range of opinion until later in the case in the expectation that the case would settle without having to reveal that his was not the only opinion that could be deduced from the facts. Further, so far as medical records are concerned, he was criticised for not drawing to the attention of the court what he must have recognised as obvious which was that a couple of the entries, upon which he relied, did not relate to the claimant but to someone with a similar name. The GMC says in *Acting as a Witness in Legal Proceedings*: '(Y)ou must take reasonable steps to check the accuracy of any information you give, and to make sure that you include all relevant information.' This is also a point worth bearing in mind in relation to the discussion above about transcripts v original records.

I am reminded that in the days before records were completely computerised, in about one in five cases, when provided with a set of general practitioner records, I would find material that did not relate to the patient. The most obvious were letters and case summaries but sometimes it was clear that handwritten entries related to another patient and often the different name, date of birth or address on the Lloyd George card gave it away. With computerised records I am not finding this less often but the *Crosby* case alerts experts to the risks.

Facts

I had this email from one of you:

> Regarding the section headed "Facts known and assumed", could this be divided in two parts covering these two issues independently? For example a person might say they were sad and anxious but surely when a person says they are sad and anxious isn't a fact until there is independent evidence of it eg doctors records recording a consultation about these symptoms. Am I being too pedantic? I'm conscious that people exaggerate symptoms very frequently and the opinion is based on a composite of what one is told and what is demonstrable fact with discrepancies between these being subject to deliberation/discussion in the opinion.

I replied:

> You are correct to make the distinction. However, in the factual part of the report and given the stage in the legal process (i.e. the court decides the facts and the court has yet to do so), it probably does not make sense to separate material into 'facts' and 'assumed facts'. Having said that, it is implicit that this distinction does exist because you certify that you have made clear which facts are within your own knowledge (and which you know to be true unless you are dishonest) and which are not meaning those facts outwith your knowledge (and which therefore you assume to be true unless you have indicated otherwise). It is a fact (within your own knowledge and in your mental state examination) that the claimant's brow furrowed when you asked him what time the post office investigators left. He tells you that

it was 11 p.m. and you can only assume that fact to be true because it is outside your knowledge. When the case goes to trial the parties may agree that they left at 11 p.m. so it becomes an agreed fact. But the defendant may say that the investigators left at 5 p.m. and if this is not agreed by the claimant, and it is material to an issue in the case, this becomes a disputed fact and the judge will have to decide whether it was 5 p.m. or 11 p.m.. So assumed facts may become agreed facts or disputed facts which have to be determined by the court.

You give the example of the person who says that they feel sad and anxious. That they told you they felt sad and anxious is a fact (and unlikely to be disputed) as also whether or not they appeared sad or anxious. Whether they did feel sad and anxious you can assume to be true if you assume that they are giving you a reliable history. But the assumption here is a particularly critical one:

> in cross-examination 'probably the most useful grounds that (counsel) can focus on are the validity and merits of any assumptions applied by the expert' (Smethurst, 2006). 'An expert report is only as good as the assumptions on which it is based' (Bell, 2010). (p. 79 in EPE).

It is critical for us because in psychiatry we are particularly reliant on reported history (assumed to be true – or not) and not always on observed signs (facts within our own knowledge) to make a diagnosis. Thus psychiatric diagnoses are more vulnerable to attack if there is reason to doubt the reliability of the subject of the report.

So, I think that all facts other than those within your own knowledge are assumed facts until they are agreed by the parties or found (or not found) by the court. Given that any assumed fact could be disputed, what is important is that their source or origin can be easily identified.

I think that the distinction you are making is explicit in my standard section:

> **1.1. The assumptions adopted**
>
> 1.1.1. I regard what the Defendant/Claimant/Complainant and any informant has told me and what is contained in the medical records and other documents as 'assumed facts'. The only facts within my own knowledge are my findings on examination of the Complainant, as set out below in the section 'psychiatric examination', and my knowledge of the practice of psychiatry.

In my factual analysis this distinction is implicit as usually I have sections on, for example, background history, medical history, account of the alleged offence/accident etc and a section on 'psychiatric examination', the former all being 'assumed facts' and the latter 'facts (within my own knowledge)'. I might in addition have a section of facts about psychiatric practice, e.g. the process of an out of hours Mental Health Act assessment, which is also 'facts (within my own knowledge of the practice of psychiatry).

You are not being too pedantic. You are looking to maximise the assistance you give to the court: separation of facts within your own knowledge from assumed facts; making clear the

> assumptions; etc. Then, as you say, you use the opinion to set out the reasoning but starting from a consideration of the reliability of the assumed facts so that if there are discrepancies or inconsistencies you deal with these first.

Some useful reading

You may never be asked to give evidence in a planning case but this paper which I discovered by accident is also of more general application:

https://www.ftbchambers.co.uk/sites/default/files/2010-craig-howell-williams-richard-honey-expert-evidence-and-how-to-be-a-good-witness.pdf

JUNE 2021

Judgments

There have been a number of interesting judgments in the last month. In the attachment, they begin with a liitgation capacity case (*An NHS Trust v P*) which is followed by a testamentary capacity case (*Clitheroe v Bond*). The case of *Beattie Passive Norse Ltd* (two separate judgments) introduces this month's 'inexpert expert of the month' or you might want to award this title jointly to the experts in *Dana UK Axle Ltd* as both cases involved experts who acted in disregard of their duties as experts. Although *Dana* was a case where technical experts were called, it is a case with important lessons of general application about dislosure of material instructions, retention of notes and records and the nature and documentation of experts' investigations and enquiries. In contrast the performance of Dr Emma Hargreaves in the Scottish divorce case *M(C)* fully entitles her to the title of 'expert psychiatric witness of the month'. Those of you concerned about attachment theory being kicked into the long grass will be pleased to see it has made its comeback in *Re TT*. We have a forced marriage case, *C*, with a lesson about setting out your relevant qualifications, training and experience. The case of *Long* is worth reading if you are instructed in cases where brain injury is an issue and in relation to neuropsychological testing. *Ihenacho* is a fitness to plead case. I am grateful to Richard Latham for bringing the Irish insanity case of *DPP v Kenna* to my attention. This reminded me that I had intended to extend my search of judgments to the Irish jurisdication and I have now made a start and been rewarded with the nervous shock case of *Foley* which provides a fascinating account of the evolution of the law on nervous shock in Ireland, has some interesting observations on bias and also raises an interesting issue about the criteria for the diagnosis of post-traumatic stress disorder.

Post-traumatic stress disorder

On the subject of post-traumatic stress disorder, one of you wrote recently:

> How are we to deal with situations where a client is providing an account of symptoms to suggest possible underlying mental health diagnoses such as PTSD even when they do not come across as convincing or unable to provide a clear account of events?
>
> An example - I recently had a client who described witnessing people dying but was unable to provide a detailed account of the incident (s). He however went on to describe flashbacks, nightmares, and other symptoms suggestive of PTSD. I did comment on the fact that he was unable to provide a detailed account but found it difficult to conclude he does not have PTSD based on his account. While I was fully aware of my duty to the court, I also wanted to

> remain as objective as possible. I was not sure how far I could go expressing my views without coming across as subjective and damaging to his case.

I replied:

> I think the problem is the way that the diagnosis of post-traumatic stress disorder has been formulated by the committees of both the WHO and the APA (DSM). As defined, post-traumatic stress disorder is a fairly unique diagnosis (in psychiatry). The diagnosis is based not just on symptoms and signs but also on aetiology. Of course a diagnosis of Klebsiella pneumonia would be based on the symptoms and signs of pneumonia but also the identification of *Klebsiella pneumoniae* in sputum or a tissue sample. But we diagnose a depressive illness or phobic neurosis or anankastic personality disorder simply on the basis of symptoms and signs and only in organic disorders, and I suppose substance use disorders, do we sometimes have an aetiological diagnosis.
>
> The problem with post-traumatic stress disorder is that, as was found in a Dutch population survey in the early 2000's, many people experience symptoms and signs of post-traumatic stress disorder, usually in response to adverse events and circumstances, but without triggers that satisfy the severity criteria for the triggering event as set out in ICD or DSM. So you can have two people with identical symptoms and signs and an identical level of impairment of functioning, one whose trigger is sub-threshold and one whose trigger is above threshold. The former does not qualify for a diagnosis of post-traumatic stress disorder and the latter does. I know of some experts, reporting in personal injury cases, who refer to the condition as 'sub-threshold post-traumatic stress disorder' which, technically is correct, but potentially misleading as it may be taken to imply that their condition is less severe than that of someone with post-traumatic stress disorder (the trigger may not have been as bad but the symptoms and signs and their effects may be just as bad).
>
> My approach is to set out information like that above, refer to the introductory section of ICD, where there are useful qualifications as to the utility of ICD diagnoses, and make the diagnosis of post-traumatic stress disorder. I also acknowledge the range of opinion: 'subthreshold post-traumatic stress disorder' and an 'adjustment disorder with other predominant (post-traumatic) symptoms' as alternative diagnoses. On occasions I have also used the sweet jar analogy: what matters is not the label on the jar but the contents of the jar.
>
> Cases such as yours appear analogous. They have the symptoms and perhaps also signs of post-traumatic stress disorder. What matters in terms of diagnosis is the symptoms, the signs and their effects in terms of impairment of functioning. Indeed, could their inability to describe the trauma(ta) be in itself a reflection of the avoidance that occurs in post-traumatic stress disorder. For the purposes of diagnosis, given what I have said above, it should not matter that you cannot identify the triggering trauma or traumata. Of course, it may matter in relation to particular issues before the court as it may make a difference to the outcome of the case whether or not the court is satisfied that a particular traumatic experience occurred in a particular country or was occasioned by a particular political, ethnic or other specific group.

Indemnity

Dr Ciarán Craven SC recently wrote to me about indemnity for experts from outside Ireland instructed in Irish cases.

> We had lined up a well-known … expert from England … He e-mailed my solicitor earlier this week in the following terms: 'I have bene told by my insurer that I am not insured for cases in Eire so I am afraid I cannot become involved in this case' (*sic*)
>
> I was aware of rumblings of this nature, in the past, but this is the first time I have encountered it. Do you have any views or insights on this? Do any MDOs provide cover for expert witness work outside the United Kingdom or do they charge an additional premium?
> The simple reality here is that it is virtually impossible to sue a witness, let alone an expert witness, arising out of that witness' role as an expert in this jurisdiction. I am aware of only two cases since the mid-1960s and, in each of those, the issue related to omissions from the reports of the surgeons (one a general surgeon, the other an orthopaedic surgeon) who provided the condition and prognosis report in road traffic personal injuries proceedings. The immunity of an expert witness, in respect of acting *qua* witness, was affirmed by the Supreme Court in *EO'K v DK & ors* [2001] 3 IR 568 (where, incidentally, the expert in question was Patricia Casey):
>
> > ' . . . the law in this jurisdiction confers upon a witness - whether expert or otherwise - immunity from proceeding in respect of a wrong committed in such circumstances. That immunity is subject to the qualification . . . that if a witness - or even a judge - so departed from the duties which he or she was purporting to perform as to abuse his position, that he would forfeit the immunity which he was abusing'. (at 576)
>
> I know the UK Supreme Court in *Jones v Kaney* [2011] UKSC 13, [2011] 2 AC 398 took a different view. However, as recently as 8 May 2019, the Supreme Court here, in *Jeffrey v Minister of Justice & ors* [2019] IESC 27 affirmed (at para 5.10 *per* Clarke CJ) the difference between English and Irish law, *viz*. *EO'K v DK* not *Jones v Kaney*.

In the meantime, I have been in touch with two of you who are experts in Hong Kong cases and again the issue of indemnity has arisen.

Leaving aside indemnity cover from the medical defence organisations, I thought that one solution might be to join the Expert Witness Institute or the Academy of Experts. I got the following response from the EWI:

> The Professional Indemnity Section covers you Worldwide (with the exception of US and Canada), the crisis containment section covers United Kingdom, The Isle of Man, the Channel Islands and the Republic of Ireland.
>
> This is based on the majority of your work being in the UK.
>
> All the documentation can be found at www.ewi.org.uk/insurance
>
> Just to clarify, the Insurance isn't included in your membership fee, it is an additional payment.

I got this response from the Academy of Experts (which includes insurance in the membership fee):

> The PI Insurance cover should cover you for cases in Ireland and the Channel Isles. If you have any specific questions in relation to the Policy, please contact the Brokers, CBC UK Ltd, on 020 7265 5600.

One of you has since obtained this more detailed response from the Academy of Experts:

> I phoned TAE this morning and they confirmed that while full membership is £305 per year, worldwide insurance for expert witness work alone (including UK & Hong Kong, but excluding North America) was available for an additional £260 PA up to £1 million, £375 PA up to 2 million, and £585 PA up to £5 million.

I am a member of the MDDUS and I obtained this response:

> MDDUS only provide cover within the UK, therefore any work completed in Ireland must be within Northern Ireland.
>
> Your current subscription would extend to provide cover for ad-hoc medico legal work carried out in Northern Ireland, Channel Islands and the Isle of Man on the condition this would be occasional work and not on a regular occurrence. The majority of your work must continue to be worked in England.

One member of the group ascertained the position of the MPS:

> MPS will provide cover only if the Dr is registered with the IMC.

It would be helpful if one of you could ascertain the position of the MDU.

Ciarán has commented further:

> This represents a potentially very serious impediment to our system of administration of justice and is difficult to reconcile with (i) our established expert witness immunity and (ii) the definition of 'practice of medicine' in the Medical Practitioners Act 2007 which is, for the want of a better expression, the threshold issue that gives rise to a requirement for registration with the Medical Council.

EWI and TAE membership

I recently attended (remotely) the EWI Annual Conference. I got rather more out of it than in previous years. I was surprised to see only a few of you in attendance and I know that many of you do not belong to the EWI (https://www.ewi.org.uk) or TAE (https://academyofexperts.org/). I do encourage you to join one or the other. They provide much in the way of training and they have helpful membership services. They also publish details of recent judgments relevant to expert witness practice (I may miss some!).

I cannot mention the EWI and TAE without also mentioning Dr Chris Pamplin's *JS Publications* expert witness register (https://www.jspubs.com/). The register is probably the most comprehensive and well-indexed register in the UK but it is the regular e-wire newsletter which makes it so useful joining this register. See https://www.jspubs.com/experts/ewire.htm for the topics which have been covered.

Redacted records etc

Dr Michael Powers QC has responded:

> There are two choices facing the expert competent to give an opinion in the instructed area (i) accept the instructions on the basis that there is sufficient information (even if not complete) for an opinion to be given but qualified by a comment such as yours or (ii) refuse the instructions on the ground that there is insufficient information upon which to provide any reliable opinion.

As to (i), surely the answer is to set out in the opinion the complete information upon which it is based and to make clear that if any further information is provided, you may need to change your opinion. In setting out that information, in some instances it may be sufficient simply to identify a document (eg a witness statement), in others, such as redacted medical records it is not. The entirety of the disclosed medical records as provided - with redactions should be appended. There can then be no possible dispute as to the information with which the instructed expert has been provided.

There is one further step, in my opinion, which the expert needs to be take. If it appears that a document has been removed which s/he would expect to be in the medical records or there are redactions which might be relevant to his/her opinion, he should say so. It would be propitious for him/her to ask his instructing solicitor to make an effort to obtain them.

You will know well that a most effective means of undermining an expert in cross examination is to ascertain the basis upon which the opinion is formed and then undermine that basis.

JULY/AUGUST 2021

The Twentieth Grange Annual Conference

I hope to see you at this year's Grange Conference at Ripley Castle, 28th – 30th September, in person preferably and if not remotely. Many of you are regulars but so far few of you have signed up. Those who have already booked want to stay in The Boar's Head, so do sign up quickly if you want to be on site.

There are bursaries available.

This is the link for the Conference: The 20th Annual Grange Conference – Education & Training Network (educationandtrainingnetwork.co.uk)

Welcome SLAM trainees

Matt Hartley has provided me with the email addresses of a number of SLAM trainees who are now receiving this bulletin for the first time. Do let me know if you have colleagues who would like to go on the mailing list.

I am particularly pleased that trainees are reading this. Established experts can do an enormous service to the administration of justice by getting trainees involved in preparing reports under their supervision.

Family Justice Council

Those of you who have been on my list for a while will know that I am on a committee of the Family Justice Council which is taking forward the recommendations in last year's FJC report on expert medical evidence in the family courts. I am also the co-chair, with HHJ Jaron Lewis of Chelmsford, of the Eastern England regional sub-committee. The primary issue that the report addressed was the shortage of doctors willing to provide expert evidence in family cases. Can you please help me in both capacities. As well as creating a database of experts who can be invited to national and regional training events, we have to find a way of attracting new experts. So, if you prepare reports in family cases, or are willing to do so, would you please let me know and allow me to give your contact details to the appropriate regional chairs. I need to know where you are based in order to do so. For

example, our Eastern Region subcommittee covers Norfolk, Suffolk, Essex, Hertfordshire, Bedfordshire, Cambridgeshire and Peterborough. Also, would all of you please think about colleagues who might be encouraged to undertake expert witness work in family court cases. I think that adult psychiatrists and child and adolescent psychiatrists are needed although in our Eastern Region I understand that the severe shortage is in child and adolescent psychiatry.

Some of you attended the symposium in March which set the ball rolling in terms of the formation of the regional committees. There is a plan to repeat that event at 5.30 pm remotely on Wednesday 13th October so if you were unable to attend in March, I suggest that you put that date in your diary. If you were not notified directly by the FJC about the march meeting, let me know and I will make sure that you get onto the invitation list. But please note that it is a repeat, so if you attended in March there is probably no point in attending in October. We plan a different national event in May 2022 but in the meantime all of the regional groups will be organising local events so if I have your contact details I can make sure that you get invited.

Judgments

I have found several judgments this month which may be of interest. In the attached cumulative compendium of judgments they begin with *R v Popola*. For those of you who prepare reports in criminal cases there are several of interest: *R v Popola* which illustrates how the courts regard brain injury in relation to mitigation, *R v Gordon* where it was sought to rely on autistic spectrum disorder in an appeal against sentence for murder and *R v Jones (Deceased)* which is an example of how difficult it is to appeal a conviction for murder with psychiatric evidence that supports diminished responsibility manslaughter. If you get instructed in a nervous shock/secondary victim case, it is worth looking at *King*. The case of *Doyle* is of interest as the evidence of treating doctors was admitted as expert evidence and there was a boundary of expertise issue. In *Dulson*, a negligence case, guidelines were the issue. *Deutsche Bank AG* illustrates the importance of sufficiently detailed itemised billing.

Please note that these are judgments up to 30th June. I have not yet looked at the more recent ones as my time has been taken up with creating this new contact group.

Billing

Now, on the subject of billing - I often find myself spending many more hours on a report than I have quoted and billing for only what I had quoted. I was advised many years ago to bill, as solicitors do, in 6 minute units. I recently billed in a LAA-funded case, where I had not reached the amount allowed, and the time spent was x hours 46 minutes which I rounded up to 48 minutes. As my invoice showed the actual time spent was x hours 46 minutes, the LAA informed the solicitors that I had overcharged by £3.60. I was asked to submit a revised invoice for the reduced amount along with a credit note to cancel the original invoice. So I have now decided to charge by the minute rather than in 6-minute units for LAA cases. I now feel less well disposed towards the LAA and will now think twice about doing small amounts of extra work on LAA cases unpaid.

Retention of records

I have had a further query about the ownership of reports and retention of records. I replied as follows:

> James Briscoe has addressed this for the revision of CR193 and I will paste here the *draft* of that section. In my book at page 62 you will find retention times for criminal cases which exceed 8 years. But I am puzzled by your reference to solicitors asking you to destroy confidential information. They may suggest destroying medical records or witness statements etc but you must keep your own notes for as long as necessary, i.e. 5 years in case of a complaint to the GMC, 6 years in case of a negligence claim against you or the solicitor etc, and thereafter as long as the nature of the case requires which means 10 years for Crown Court criminal cases and up to 20 years for homicides etc. And it does also mean making sure that as your age advances your executors know what to do with your files when you die.
>
> **Confidentiality**
>
> An expert report, once completed, generally 'belongs' to those who gave instructions for it and not to the person assessed. In the criminal court, the defence, the prosecution or the court will 'own' the report. In the family court, where a single joint expert has been appointed, the report belongs to the court. In private law family proceedings and where the report has been obtained by a litigant in person (p. 00), however, the subject of the report may 'own' the report. In any event, the *information* within the report does still 'belong' to the person assessed, and experts should strive to respect the normal duties of confidentiality. This should include proper procedures for the secure storage of documents and records, and the use of passwords and/or encryption to ensure the security of electronic files. The duty of respect for the process of justice determines that experts should retain all their notes that do not form part of the litigation bundle and which are personal to them. They should destroy all other information with which they may have been provided once the case has been completed.
>
> **Retention periods**
>
> Although the period required for this varies according to the nature of the case, for example ranging in criminal cases from one to, for serious cases, 20 years, according to the Information Governance Alliance records management code of practice for health and social care, records of medicolegal assessments would fall into the basic health and social care retention period of 8 years. It is worth noting that the subject of a medicolegal assessment has 6 years to bring a negligence claim against an expert and five years to make a complaint to the GMC.

James has added a comment to this and to which I have replied:

> J: Although I wrote this section, I have not specifically addressed the position when an expert retires from active medico-legal practice once all cases have been concluded. Do the rules of retention still apply? And what if an expert has taken themselves off the medical register? There is a parallel with being sued post-retirement as well.
>
> K: They do need to be kept and this means giving appropriate instructors to executors.

I would add that retirement and deregistration make no difference. Even death makes no difference – see *McHugh v Gray* on p. 54 in the book.

Membership of the Faculty of Forensic and Legal Medicine

In case you missed it, a month or two ago there was an announcement in the *BJPsych* by the Faculty of Forensic and Legal Medicine of the RCP pointing out that forensic psychiatrists can qualify for Membership of the Faculty of Forensic and Legal Medicine (MFFLM) 'by equivalent qualification':

Member By Equivalent Qualification

Calling all Medical Coroners, Forensic Pathologists, Forensic Psychiatrists and Forensic Odontologists. You may be eligible to be elected to Membership under the equivalent qualification clause subject to the criteria listed below:

- …;
- Forensic psychiatrists who hold specialist registration with the GMC as a Forensic Psychiatrist;
- ….

If you are a forensic psychiatrist, I encourage you to consider applying for Membership by this route. If you are not a forensic psychiatrist you can apply for membership in the category of 'affiliate' and also obtain the FFLM's Diploma in Legal Medicine (DLM) and MFFLM by examination.

ICD or DSM?

Someone recently asked me:

> A colleague has suggested that the DSM-V may be used in the UK instead of the ICD 10 or ICD 11 when diagnosing ADHD. This is a court matter and I wanted to make sure that I had my understanding correct as I had understood that in a formal sense, the ICD 10 or 11 was the formal and correct diagnostic manual to use rather than the DSM5. Am I correct?

I replied:

> In court you can use either. But you need to be able to justify your reliance by reference to how the criteria came about, limitations on application to court issues etc (see intro). If there are differences as there are for some disorders, be able to explain the significance. ICD only has superiority in clinical practice in UK where statistical returns to NHS (are they still done?) use ICD. I prefer ICD as more flexible and so fewer NOS diagnoses. Must write my

> paper on use of ICD and DSM in litigation. Will email you something I sometimes attach as appendix

I attach that document to this email.

The 'Devonshire' judgment (Devon Partnership NHS Trust v Secretary of State for Health and Social Care [2021] EWHC 101 (Admin))

One of you wrote:

> You may be amused (or not, if you get a lot of this sort of thing) at a conversation today between myself and an AMHP regarding my recent 1st Recommendation for Detention under Section 2 of the Mental Health Act.
>
> It was put to me that my recommendation, based as it was on remote consultation alone, was not legally valid following the Devonshire ruling.
>
> I responded that, given that I had not met the judge responsible for the ruling in person, their opinion was similarly not legally valid either!
>
> More seriously, I put the argument that our Trust (covering 4000 square kilometers) should contest the elevation of what is a best practice guideline to protocol, operates to the detriment of patient care (in that there is now a need to arrange another two medical recommendations, etc).
>
> I was wondering if there has been any contest to this ruling and indeed how one would go about it?

There has not been any contest to this ruling as far as I know but there has been a plethora of guidance consistent with it. In this case the court was asked to exercise its power to use a declaration as to the construction of an enactment and it decided against making a declaration which would have resulted in the MHA being so construed as to permit remote assessments for Part II applications. The court indicated that if remote assessments were to be allowed, this would be a matter for Parliament, i.e. it would be for Parliament to change the law. I simply do not know what process of appeal might apply in such a case. I assume that it would be necessary to argue that it was unreasonable to have had regard to one or more of the six considerations on which the court relied. But as there has been no appeal, I assume it is because none of those considerations appeared unreasonable.

Maudsley Hospital Prescribing Guidelines

Gareth Vincenti draws our attention to the publication of the 14th edition of the Maudsley Hospital Prescribing Guidelines on or around 17th June.

Three buses in a row

Within a month or so of each other Gwen Adshead's *The Devil You Know* and Taj Nathan's *Dangerous Minds* have been published with predictably favourable reviews in the national newspapers. They come hard on the heels of Richard Taylor's *The Mind of a Murderer.* I recommend them all. It will be interesting to see if any reviewers compare them.

I am reading them in parallel. In Taj's book I have just been reading about his cross-examination on voluntary v involuntary consumption of alcohol in a manslaughter diminished responsibility case. Although I have addressed this in reports, I have never had to address it in oral testimony as a trial issue and although there are Court of Appeal judgments which deal with this, I have never seen a transcript of a cross-examination on this point. But Taj's account of his experience is pretty close to that and I think that this section is well worth reading so before I next give an opinion on this issue I will be reminding myself of how the evidence is likely to be tested by re-reading Taj's account.

AUGUST 2021

Welcome to Helen Whitworth's trainees

This bulletin is now going out to trainees who work with Helen Whitworth. I am happy to respond to enquiries from trainees as well as established experts.

Recent judgments

The summaries of judgments added since the July bulletin begin with *Wigan*. This is probably of more importance as a tragic deprivation of liberty case, especially for CAMHS psychiatrists, but there are some learning points relevant to expert witness practice. *TMO Renewables* has no psychiatry in it but introduces this month's unsatisfactory expert witness. *Walkden* is interesting as it is a case in which an expert psychiatric witness appears to have been regarded as going outside their expertise in opining that the stress of an accident caused the claimant's heart attack. *Ahmed* is an Irish Medical Council case but of relevance outside Ireland in relation to the matter of expert evidence and the ultimate issue. *Aderounmu* is about litigation capacity but as is often so it has learning points in relation to other capacity assessments. *Lonsdale* provides similar learning points but it is a testamentary capacity case.

New Forensic Sciences Regulator

Gary Pugh OBE has taken over from Dr Gillian Tully CBE as the Forensic Sciences Regulator. Forensic science experts are regulated more than other expert witnesses and expert psychiatric witnesses do

not come within the ambit of the Forensic Sciences Regulator (FSR). However, it is worth keeping abreast of developments in the regulation of forensic scientists and the FSR produces guidance which is relevant to expert witness practice in general.

Joint Statements Under Part 19.6 of the Criminal Procedure Rules; FSR-G-233

By way of example the FSR's guidance on expert witness joint statements ordered by the court under the CrimPR (http://www.gov.uk/government/publications/joint-statement-guidance) is worth noting in that it deals with the extent to which the experts have to set out reasons for the points on which they are in agreement:

> The reasons for any agreement (pragmatism suggests this could be quite brief)

There does not appear to be similar guidance from the FSR on joint statements prepared with the agreements of the parties under CrimPr 19CPD1 (which does not require reasons for agreement, only reasons for disagreement).

Changes to the Criminal Procedure Rules

I have learned about these changes to the Criminal Procedure Rules in the newsletter of the new Forensic Sciences Regulator and quote him here in full:

> In October 2021, the Criminal Procedure Rules (CrimPR) will change. Some of these changes relate to the use of expert evidence. The provisions of Part 19 apply to expert evidence of opinion. The CrimPR will be amended to allow the court to apply the key provisions to expert evidence of fact. The impact of this change may be limited. Many of the requirements of Part 19 reflect obligations created by case law in circumstances which drew no distinction between evidence of fact and evidence of opinion. Further, experience shows it is relatively rare for an expert to offer no opinion in a report.
>
> The provisions of Part 19 will be amended to require a party seeking to adduce expert evidence to explain how the facts stated in the report are admissible if that is not clearly stated in the report. While this is an obligation placed on the instructing party, expert witnesses may wish to review their processes to assist instructing parties to comply.
>
> Potential considerations include the following.

• Is it normal practice to state, in the reports, the fact relied on and the basis of reliance on those facts? If not, this may be useful.

• The form associated with this provision may require the party to identify facts stated in the report by the paragraph in which they appear. The numbering of paragraphs in reports may be useful.

As the FSR observes, the impact of this change may be limited as it is rare for an expert to offer no opinion in a report. However, insofar as expert evidence of fact (or what the GMC, the Academy of Medical Royal Colleges and Her Majesty's Courts and Tribunal Service term 'professional evidence') may be given, for example, by a psychiatrist as to the history of a patient under their care who is charged with a criminal offence, it is likely that this means that such reports will need to comply with CrimPR.

Academy of Experts training courses

If you are a member of the Academy of Experts, you will know about its training. If not, got to https://academyofexperts.org/training

Psychiatric expert witnesses needed

Kai Luckham who is in the Stockport office of Bakers, Solicitors, a firm which specialises in crime, family and motoring cases, is looking for psychiatrists who can provide expert evidence. If you can assist, please contact her KLuckham@bakers-solicitors.com

Cases against the medical profession

My summaries of judgments include a number of the cases reviewed by Marina Wheeler QC (https://ukhumanrightsblog.com/2021/06/18/cases-against-the-medical-profession-an-extended-review-by-marina-wheeler-qc/) but she includes others which may be of interest.

Section 12 approval

I have recently responded to a query about section 12 approval and expert psychiatric evidence. The query was in the following terms:

> Does an expert in family courts need to be s12/AC approved? That is a factual question. Having briefly looked at the relevant chapter in *Rix's Expert Psychiatric Evidence* I cannot see that they necessarily need to be although they might want to, either to demonstrate their competence and expertise in psychiatry (and arguably not being s12 approved might put them at a disadvantage) or in the unusual situation that care proceedings could lead to detention under the MHA of a child (although I'd imagine that would be extremely rare).

I replied:

> It is not necessary to be s 12 approved to act as an expert in any court. Even in criminal cases, where issues of fitness to plead, insanity and sentencing under Part III arise, it is not *necessary* to be s 12 approved although, if not, that would then necessitate the other opinion / recommendation being given by a s 12 approved doctor.

In any case if the lawyers want to play 'My expert is better qualified than your expert' it is a disadvantage not to be s 12 approved.

> In the family courts there is no requirement that the expert should be s 12 approved. But, in the unlikely event of having to recommend admission under the Act, again if not s 12 approved, the other person recommending it would need to be s 12 approved.

Special measures / vulnerable witnesses / intermediaries

If you are involved in a case where it may be appropriate for special measures to be applied because a witness (or defendant) is vulnerable, there is helpful guidance from the CPS: https://www.cps.gov.uk/legal-guidance/special-measures

Family Justice Council webinar (MS Teams)

Experts and the Family Justice System: Widening the Pool
Wednesday 13 October 2021

5.30pm to 7.30pm

Due to the over-subscription of the previous webinar in March 2021, the Experts Sub-Committee of the Family Justice Council invites anyone who missed out on that event to register their interest in this webinar: *Experts and the Family Justice System: Widening the Pool.* The event aims to explain and promote expert witness work in the family courts and is open to the judiciary and the legal, medical and allied professions. It is particularly aimed at health professionals who are either new to expert reporting or wish to become experts.

To register your interest in this event, please notify the FJC Secretariat at fjc@justice.gsi.gov.uk by 1pm on Friday 1 October 2021. Please advise your profession and organisation. The FJC will aim to confirm a place and send joining instructions by Tuesday 5 October 2021.

There is no charge for attending this event.

OCTOBER 2021

Recent judgments

In preparation for my case law update at the 2022 Grange Annual Conference I am starting a new compendium of judgments. It is attached.

The Irish case of *Sweeney v VHI* is interesting as it deals with the issue of whether or not the expert is part of their instructing party's team. In my book, I have suggested that you should be prepared to point out, particularly at conferences with counsel and during a trial, that you are not part of the team. I think that this can be modified to the effect that you can be part of the team but with different status to the other team members as, unlike the others, you owe your duty to the court and not to the team. Recently in the same case, both at a conference and in conversation with counsel in the court, I said 'we …' and then had to correct myself and say, 'Sorry, I mean "you" as I am independent …'

AHA v The Secretary of State for the Home Department is an immigration and asylum case but is of general application as to the nature of expertise and the need to provide sufficient information as to methodology and data for the court to assess the reliability of, and thereby weight to be attached to, expert evidence.

Re CSB introduces this month's inexpert expert and has more lessons for accountants but there are some learning points of general application.

Hard on the heels of Sir Nigel Poole's Grange Conference judicial lecture on expert evidence in capacity cases, we have *Re BU*, which is essential reading if you are considering capacity to have contact with, marry or enter into a civil partnership with another person. I do not recall a case previously where capacity to marry and capacity to enter a civil partnership have been compared. This is also the first time that I have seen coercive control so clearly set out in expert evidence.

Although *Good Law Project Ltd* concerns the admissibility of the evidence of an economist, it is of general application and it illustrates how failure to comply with procedural rules can simply result in the court refusing to admit the expert evidence.

If you have watched BBC TV's *Bang Goes the Theory* you are bound to be interested in *Stansfield v BBC* but the real interest will be for psychiatrists and psychologists who grapple with mild traumatic brain injury in personal injury cases. It also shows how the courts get to grips with what DSM now calls somatic symptom disorder.

Only cardiologists and haematologists will want to read in full my summary of *Thorley v Sandwell & West Birmingham Hospitals NHS Trust* but if you are relying on guidelines in a clinical negligence case it is worth reading and there are some points to bear in mind where you rely on the results of published studies.

Obeying the rules

I often comment on how common it is to read an expert report in a criminal case which ends with the a declaration of compliance with the Civil Procedure Rules Part 35 and the wrong statement of truth. Also it is not uncommon to read a prosecution expert's report in a criminal case that does not include the extra declarations required under the Criminal Procedure and Investigations Act 1996, as amended, which include a declaration confirming that you have read and followed the guidance contained in *Disclosure: Experts' Evidence and Unused Material* and recognise the continuing nature of your responsibilities of disclosure. Although the on-line appendices to my book (Appendices 13 and 14) can be downloaded and adapted, I need to draw your attention to the fact that, too late to include reference in the book, the CPS *Disclosure: Experts' Evidence and Unused Material* was updated in 2019 (https://www.cps.gov.uk/legal-guidance/cps-guidance-experts-disclosure-unused-material-and-case-management) with some significant changes.

There is now a requirement that "Upon receipt of instructions you are required to complete a self-certificate (the Certificate) in every case that you are instructed as an expert witness for the Prosecution. The completed Certificate should be sent to the disclosure officer or investigating officer." Hitherto I thought it sufficient to include the declaration in the report.

It is also worth looking at 'Appendix A: Experts index of unused material'. I refer to this in brief on p. 91 in the book. So far I have not used the template at Appendix A and have opted for a simpler addition to the appendix in which I set out what I now call the 'Documents, materials and unused material'. This is an example from a recent prosecution report:

Date	Nature of material	Subject	Comments
12.7.21	Email CH to KR	Initial enquiry	Para 1.2
12.7.21	Email KR to CH	Positive response	
12.7.21	Email CH to KR	Acknowledgment	
12.7.21	Email CH to KR	Clarification	

14.7.21	Email CH to KR	Terms of reference	
15.7.21	Email KR to CH	Confirmation that falls within my expertise	
16.7.21	Email CH to KR	Attaching updated Early Investigative Advice	
20.7.21	Email KR to CH	Further confirmation	
20.7.21	Email CH to KR	Agreement to instruct	
20.7.21	Email KR to CH	Address for delivery of disk	SENSITIVE
21.7.21	Email CH to KR	Re delivery of disk	
27.7.1	Email CH to KR	Disk codeword and attaching Schedule of Material	? SENSITIVE (codeword) See Appendix 4
16.8.21	Email KR to CH	Confirming receipt of disk	
16.8.21	Email CH to KR	Acknowledgment	
13.9.21	Email KR to CH	One day delay	
13.9.21	Email CH to KR	Acknowledgment	

If you use my 'File Front Sheet', which is on-line Appendix 5 to my book, it should be easy to compile a table like that above. However, I intend to do some work on the CPS template with a view to producing a simpler version suitable for most prosecution psychiatric reports.

There is no comparable disclosure obligation if you are instructed by the defence in a criminal case but it is sensible to work on the basis that any communication may be disclosed even though it is legally privileged. I've lost count of how many times my draft reports have been inadvertently disclosed so be aware that anything that you write, or say, in the course of a case may be revealed in evidence and, if you have not been careful, used in cross-examination either to challenge your credibility or your evidence or both.

Training and indemnity matters

I am grateful to one of you for sending me a specialty registrar job description which includes the following paragraph:

> Dr X regularly provides psychiatric reports for the Courts and is a Medical Member of the Mental Health Review Tribunal (Y Region). The post will therefore also provide an

> opportunity for a first year SpR to be introduced early to medico-legal practice including the supervised writing of reports for a variety of external bodies in matters relating to psychiatry.

I hope that those of you who are NHS consultants with specialty registrars will be able to persuade your trusts' HR departments to include a similar paragraph in you SpR job descriptions.

But give some thought to the issue of indemnity. One of you wrote to me recently expressing concern because they had received a claim in relation to supervising a senior trainee acting as an independent expert witness in a case which concluded some years previously. They thought that it was a fairly straightforward matter to which to respond, but the issue with which they were grappling was indemnity for this work (independently supervising a trainee who was acting as an independent expert). The consultant had always assumed it would be covered within their medical defence organisation cover but their MDO questioned this. In the event, their MDO informed the expert, within a few hours, that their medicolegal supplement did include this. However, you should check with your own MDO.

Breach of duty and the ultimate issue

I recently received this query:

> If asked whether an agreed failure in an aspect of psychiatric care of a patient represented a breach of duty, are you comfortable expressing a direct opinion about a breach (i.e. using the words there was - or was not - a breach) or do you use phrases such as a 'fell below an expected standard' or the like. I prefer the latter, but I am being pushed to be more direct. Is it okay for an expert to talk in what I consider to be legal terms (i.e. there was/was not a breach)?

I deal with this on page 89 in the book. Further, whether or not a defendant owes a duty of care to a claimant is a matter of law and so also is the scope of the duty (*De Sena Notaro* [2020] EWHC 1031 (Ch)). In a civil case there is a provision under the Civil Evidence Act 1972, s 3(1):

> 'where a person is called as a witness in any civil proceedings his opinion on any relevant matter on which he is qualified to give expert evidence shall be admissible in evidence'.

The key word here is 'qualified'. I have already brought to your attention *Ahmed v The Fitness to Practice Committee of the Medical Council* [2021] IECA 214, where:

> In this case the allegation of poor professional performance was a judgement regarding medical standards. Therefore, it was a matter of medical evidence and in the absence of evidence, the Committee could not "join the dots". The absence of skill or knowledge was an issue of medical standards and evidence of that was required. It was up to the Committee to make its decision based upon its assessment of the evidence. Although an expert gives his or her evidence on the ultimate issue, it remains the role of the Committee

> to decide if that evidence has reached the standard of proof required for a finding of poor professional performance.

As a psychiatrist you are *qualified* to consider evidence which the court cannot understand without your assistance, "join the dots" and then give your opinion as to whether the psychiatrist has fallen below the standard of the ordinarily competent psychiatrist acting with ordinary care and then leave the court to decide, having regard to all of the evidence in the case, whether the evidence has reached the standard of proof for a finding of negligence.

I think that what matters is how you express yourself. I am mindful of what Jacob J said in *Routestone Ltd v Minories Finance Ltd* [1997] BCC 180: there is no need to 'simply creep up to the opinion without giving it'. But appropriate deference is needed:

> In this case I have been specifically asked whether or not there was a breach of duty. I am mindful of the fact that this will be an ultimate issue for the parties to agree or for the court to decide. As an expert it is not for me to decide the ultimate issue. However, I recognise that the court may need assistance as to medical standards. It is on that basis that I offer assistance by way of expert analysis of the factual evidence and the provision of expert opinion as to the extent to which the required standards have been met. In this case, I am of the opinion that the defendant's psychiatrist has/has not undershot the standard reasonably expected of a reasonably competent psychiatrist carrying out the functions of a psychiatrist. It therefore appears to me that there has/has not been a breach of duty on the part of Dr X but I acknowledge that it will ultimately be for the court to decide whether or not there has been a breach of duty having regard to its judgment as to whether the evidence in the case, of which my evidence is but a part, has reached the standard of proof required for such a finding.

I have put this together for the first time having regard to the terminology in the two recent judgments cited.

Fees and expenses

In my latest skirmish with the Legal Aid Authority I have been refused payment because I have shown a charging rate of £10.8 per 6 minutes and asked to resubmit my invoice quoting £108 per hour! The total is the same either way but I am keeping the LAA bean counters in employment (and my bookkeeper).

More importantly, although I have recently found out how much the CPS and the LAA allow for an overnight stay outside London, I was unable to find out what HMCTS allows for a defence expert. I charged £91 (which I think is what the LAA recently allowed) but I have been informed that it is

£81.15. To my great relief I am simply being paid slightly less than I claimed. If it had been the LAA, I would have had to issue a credit note and submit a new invoice.

The Criminal Procedure Rules, r.19.9

A recent case has reminded me of CrimPR r.19.9:

"19.9.—(1) This rule applies where—

(a) a party introduces expert evidence under rule 19.3(3);

(b) the evidence omits information which it otherwise might include because the party introducing it thinks that that information ought not be revealed to another party; and

(c) the party introducing the evidence wants the court to decide whether it would be in the public interest to withhold that information.

This rule may be of use to you if, in the course of a psychiatric assessment, you are provided with information which, if it became known to the adverse party or the public, might lead to a real risk of serious harm to a third party or third parties. In such a case I suggest that you identify this information, perhaps by highlighting, in the report and, suggest to your instructing solicitors that the court should make a decision as to whether it would be in the pubic interest to withhold that information. The solicitors can then prepare an application to the court which identifies the highlighted information, explain why it would be in the public interest to withhold it, and omit the highlighted information from the copy of the application that is served on the adverse party.

Training and courses

The EWI has a number of courses etc which may be of interest to you:
https://www.ewi.org.uk/Training-and-Events

Reports for Scotland

One of you has asked about any special requirements for reports for the jurisdiction of Scotland. There are. They are in the book. But since then there has been the case of *Reactec Limited v Curotec Team Limited* [2020] CSOH 77. This has established that the expert declarations used in England and Wales can be used in Scotland, that the expert declaration is not set in stone and can be adjusted according to the nature of the case and in a report in Scotland have regard to, and acknowledge reference to, the Law Society of Scotland's Expert Witness Code of Practice.

Reports in criminal cases in Northern Ireland

Someone attending The Grange Conference asked about the criminal law of Northern Ireland. This should be covered sufficiently in the book as we were assisted by Dr David Sharpe QC SC (who spoke at the Conference). If you find that something is not covered, please let me know and this can be corrected in the third edition.

NOVEMBER 2021

Recent cases

The recent cases in the attachment begin with *TMO Renewables Ltd v Yeo* [2021] EWHC 2773 (Ch) which again underlines the importance of the court being able to assess all of the factual evidence on which you rely and specifically any interviews you have conducted. The Rangers Football Club case of *JAMES STEPHEN* illustrates aspects of expert witness practice which may result in a challenge to the admissibility of the expert evidence. *AI v The Secretary of State for the Home Department* [2021] UKAITUR PA020572020 is important as it deals with the meaning of 'vulnerable witness' in the context of asylum and immigration cases. *Director of Public Prosecutions v C* [2021] IESC 74 is an Irish judgment that includes an unrivalled judicial exposition of the difference between expert evidence of fact (sometimes known as professional evidence) and expert evidence of opinion. Finally, *AB v Her Majesty's Advocate* [2021] HCJAC 43 should be required reading for any expert who gives evidence as to their assessment of risk.

I am grateful to Dr Michael Powers QC for bringing to my attention this news report of a case in which a medical expert has been ordered to pay more than £50,000 for wasted costs after his report was used as the basis for an abortive negligence claim https://www.lawgazette.co.uk/news/grossly-unhelpful-expert-ordered-to-pay-50k-wasted-costs/5110385.article. I have yet to see the judgment so perhaps more of this case next month. I have looked at cases reported up to 3 November.

Withholding information in the public interest

Some experts may not be aware of an amendment to the Criminal Procedure Rules Part 19 made, I think, in April 2019:

"19.9.—(1) This rule applies where—

(a) a party introduces expert evidence under rule 19.3(3);

(b) the evidence omits information which it otherwise might include because the party introducing it thinks that that information ought not be revealed to another party; and

(c) the party introducing the evidence wants the court to decide whether it would be in the public interest to withhold that information.

(2) The party who wants to introduce the evidence must—

(a) apply for such a decision; and

(b) serve the application on—

(i) the court officer, and

(ii) the other party, but only to the extent that serving it would not reveal what the applicant thinks ought to be withheld.

(3) The application must—

(a) identify the information;

(b) explain why the applicant thinks that it would be in the public interest to withhold it; and

(c) omit from the part of the application that is served on the other party anything that would reveal what the applicant thinks ought to be withheld.

The provision may assist in a case where you are given information, by the subject of your report or someone else interviewed, which in your professional judgement you consider there might be a public interest in asking the court to withhold on the basis of a real risk of serious harm to a third party or third parties. What you need to do is identify clearly for your instructing solicitors (a) the information that it might be in the public interest to be withheld and (b) the reasons why you consider that revelation of this information might lead to a risk of serious harm to a third party or parties. You do not have to be certain that harm might result only that it might result. Responsibility for revealing, or not revealing, this information then becomes a matter for judicial decision.

Report needed in potential appeal to the Crown Court against conviction

I have been approached directly by Aaron Allen alondona39@gmail.com whose legal team needs a psychiatric report in connection with a proposed appeal against his conviction. I do not have any details of the case. If you might be able to assess him before the end of November, please let him know and he will put you in touch with his solicitors.

Academy of Experts Guidance on Joint Statements

The Judicial Committee of the Academy of Experts has just published new guidance on experts' joint statements. You can find it at https://academyofexperts.org/practising-as-expert/expert-witness/guidance-on-joint-statements/?mc_cid=4b91270ecb&mc_eid=18ce42b476#page_content or at least I hope that you can. I was not asked for my membership number or a password. I have yet to set out my joint statements using with columns and rows but will now consider doing so if that is what judges find helpful.

You think that the subject of your report is being dishonest or their history comes across as too rehearsed

I had this request from one of you: "Do you have any pearls of wisdom, advice or guidance in regards to civil reports (personal injury claims) when you feel the client is not actually being honest and comes across as too rehearsed?"

I replied:

Honesty

First, remember that it is the court that decides whether or not a party or a witness to proceedings is being honest.

Second, you must be sure of your facts if you assert dishonesty. I suggest that you express yourself cautiously, "Insofar as it might be concluded that the XXX is dishonest because [the reasons why you think they are dishonest], this may call into question the reliability of the account I have obtained from the XXX".

Third, you should make a distinction between dishonesty which requires no psychiatric expertise for its identification and dishonesty which requires psychiatric expertise for its identification. The former, because it could be picked up by anyone in the litigation, is merely something which you acknowledge could affect the reliability of their account to you. The parties will agree between themselves or the court will make findings of fact taking into account the assessment of the person's reliability. The latter needs more detailed treatment on the basis that, if it is dishonesty, which could not be identified without expert assistance, you need to spell out exactly what it is that causes you to *question* the person's honesty. But I emphasise calling into question the person's honesty and not making a finding of dishonesty. You may be wrong. So leave it for the court to decide.

Too rehearsed

An account which is (too) rehearsed may be an untruthful account but I suggest that you stick to your observation that the account seems 'rehearsed' (not 'too rehearsed'). Stick with the fact that it appears to be a rehearsed account and leave the court to draw any inference. A rehearsed account may be a genuine account. There may be an innocent reason for the account appearing rehearsed. I suggest something along the lines: "Compared to when I have taken a similar history in clinical practice, it appeared to me that the xxx's account was rehearsed in a way which in my clinical experience is unusual." Concentrate on setting out what made the account appear rehearsed.

Alcohol, parasomnias, statistics and Sally Clark

In a possible automatism case I have recently been in touch with a neurologist, Neil Munro, and he sent me a copy of his paper on alcohol and parasomnias. I thought that I had filed it away for this bulletin but cannot find it. However, I have accessed a version on the internet and I attach a copy. If you want a better copy I can put you in touch with him. Of course this should be essential reading if

you are instructed in a parasomnia case where alcohol is involved but I found his statistical approach to court verdicts and his analysis of the statistics evidence in the Sally Clark case fascinating.

Insanity defence dilemma

I set out here verbatim an email exchange in which I recently became engaged. Q is the person who asked the question. R is the person asked the question. I was then drawn into the exchange.

Q. Must the two experts agree that insanity is met for the court to hear the defence? Or is it just 2 experts giving evidence. CPIA and CPIA-R silent on agreement, as is Blackstone's and Archbold. Do you know/know of any case law? Currently in court…

R. I don't ... Common sense surely requires agreement; suppose you had two experts both saying 'not insane', could the court still find insane? Surely not. So surely need agreement.

KR. I am not aware of any case law on this, but ….

If two registered medical practitioners, including one approved under s 12, agree that the criteria are met, I would expect the judge to put it to the jury with an appropriate direction about reaching their own verdict but there being (which is usually the case) no reason to disregard the expert medical evidence. I was once in the court where the judge gave the direction, asked the jury to put their heads together without retiring and elect a foreman, and he then asked the foreman to return the verdict of NGRI. It is more usual to send out the jury for long enough for everyone to boil a kettle.

It seems to me to be permissible, particularly in a finely balanced case, for the issue to go to the jury even if only one of the two doctors is supporting NGRI because the jury has to reach its verdict on all of the evidence and on the tested evidence. Upon testing the evidence may more strongly support the NGRI verdict, perhaps because the expert who was against it has made concessions etc, or the evidence may be weakened by cross-examination of the expert who opines NGRI.

So I think that it is simply two doctors giving evidence, not necessarily agreeing.

Of course, if D says NGRI and the pros says not NGRI, D ought to have a second doctor supporting NGRI and failure to call its second expert, whose evidence the court has given D permission to obtain, could lead the prosecution to call that expert in the belief that D's second expert has opined not NGRI.

Am I right that there is an analogy with DR in that the failure of the doctors to support DR does not prevent the jury returning a verdict of DR? Obviously this would be exceptional but I think it can happen. I am going to look this up.

KR. I can't find it in Blackstone which means that I probably read about the case years ago in Smith and Hogan but I no longer have a copy. But the more I think about it, subject of course to complying with the judge's directions, it is for the jury to assess the medical (and other) evidence and use it to decide the ultimate issue. The jury's starting point will be the expert evidence of fact, such as particular delusions, and the experts may agree about these, they may agree that there is a defect of reasoning, they may then disagree as to nature and quality or wrongfulness but ultimately those are matters for the jury. A jury may have difficulty rejecting expert evidence of fact but it must be open to the jury, for a variety of reasons, to reject expert evidence of opinion, such as the opinion of the prosecution expert that D did know the nature and quality of the act or did know that he/she was doing wrong.

Q. I wonder if we could write a little bulletin of some sort about this possible lacuna. I find it difficult to believe that today is the first time it has ever come up or been thought about! Also it makes me wonder how many insanity defences were not raised because of the lack of two reports agreeing.

R. KR is, of course, correct. One proviso (see my earlier email) is that in interpreting 'know' the expert would be taking a view on the legal meaning of that term, and so would be expressing law and offering an opinion on the ultimate issue.

R. As a simple way of conceiving it, is it not that, in order to raise the defence of insanity, there need to be two psychiatrists 'supporting' it (though problems ? re ultimate issue avoidance, eg re meaning of 'know'). But that the evidence of either can be shot down and/or rejected by the jury (albeit judges tend to lead the jury by the nose to insanity if both reports support it)?

Q. The Judge ruled that the defence of insanity could not be put forward since the two doctors did not agree. The defendant was therefore unable to progress an insanity defence.

On this basis, it was presented to the Court that one of the reasons that an insanity defence was sought to be run was owing to the risk of a S45A disposal from a guilty plea. The Court was able to progress with a situation described as similar to a "Goodyear Hearing" which I understand is an "advanced sentence indication" whereby a S45A was excluded by the judge, and an indication that a S37/41 would be an appropriate outcome on the basis of indication from the reports prepared already and the experts being present in Court (myself for the defence, David Ho for the CPS).

In the end, D pleaded "Guilty" on the basis of the above, and a disposal under S37/41 was given on the same day, with the RC (who was not one of the experts) providing written evidence of availability of the bed; it was therefore all completed quite quickly in the end.

The procedure by which a defendant can obtain an indication as to the sentence to be imposed upon a plea of guilty is governed by the decision in *R v Goodyear* [2005] EWCA Crim 888. At the defendant's request, the court can indicate the maximum sentence it would impose were the defendant to plead guilty at that stage of the proceedings. Proceedings should be held in open court. (https://www.cps.gov.uk/legal-guidance/sentencing-overview)

DECEMBER 2021

Apologies … and especially to psychologists …

I am sorry that I sent you all a blanket email yesterday asking if you could assist Chris Buller in locating a psychiatrist on the GMC's specialist register in the categories of both general adult psychiatry and learning disability but it was a useful exercise.

First, there were several responses which I hope will have enabled the solicitors to find the expert they want.

Second, there were many responses which reminded me of what we wrote in the RCPsych CR193 (and which is unlikely to change substantially in the ongoing revision):

> Notwithstanding the judgment in *Pool*, the Royal College of Psychiatrists recognises that, although a doctor's category of specialisation on the specialist register is evidence of achieving skills and a particular level of competence, this may have been many years earlier and many doctors, over their careers, move practice and acquire considerable expertise in areas not recognised by their category on the specialist register, but evidenced through their continuing professional development and the processes of appraisal and revalidation.
>
> In some cases involving older persons the most appropriate expert may be a psychiatrist whose specialty is old age psychiatry; but in some such cases the most appropriate psychiatrist may be one whose specialty is forensic psychiatry. In the case of an older person with a learning disability (now more commonly known as an intellectual disability) who is involved in criminal proceedings, the most appropriate expert might be an old age psychiatrist, a forensic psychiatrist or a learning disability (intellectual disability) psychiatrist. In a personal injury case involving a working-age adult the relevant specialty might be general psychiatry or forensic psychiatry. In many cases there is a preference for forensic psychiatrists because their forensic skills are regarded as desirable, if not necessary, when

> evaluating evidence, but this preference may be based on a misunderstanding of the analytical skills of psychiatrists who are not forensic psychiatrists.

Third, I apologise in particular to the psychologists who got this email but some of their responses were informative. I do not know anything about his case but it may be one in which a psychologist could be of as much assistance to the court or perhaps even more so. I am reminded of a recent case of a man with autism spectrum disorder and how valuable the evidence was of the psychologist.

Recent judgments

This month's recent judgments start with *A Local Authority v X* which I found quite fascinating as I had never heard of quaternary dissociative identity disorder and on reading about the illuminati, although I am still not minded to read Dan Brown, I was prompted to read about their history. *ECU* reiterates some of the usual points about errors, change of opinion and assumptions but is interesting in relation to degrees of certainty and the standard of proof. Next is the judge's ruling on the prosecution expert in *R v Grusza* which I bring to your attention with some regret. As you know, I do not like the way that experts can be named and shamed in public judgments and so I have anonymised the expert but I know that he/she is known to some of you. It is sad to read. I will deal in more detail with the duties of the prosecution appointed expert below. *Martin* is yet another personal injury/brain injury/frontal lobe case and it illustrates the evidential value of psychometric testing in comparison to 'real world' evidence. *Sullivan* should be mandatory reading if you have an employment appeal tribunal case where the issue is the prognosis of the appellant at the time of the original tribunal. Finally, *JB* is back in the legal news. Now the Supreme Court has joined the fray, it has confirmed that if he wants to engage in sex he has to understand that sexual relations must only take place when, and for only as long as, the other party is consenting but that's not an end to it as the case has been sent back to a lower court for a reconsideration on the basis of the factual evidence. *JB* is also of interest as it addresses the status in the UK of the United Nations Convention on the Rights of Persons with Disabilities.

Calling forensic child and adolescent psychiatrists

The Crown Prosecution Service, through the officers in the cases, generally relies on a register held by the National Crime Agency when it wants to instruct an expert. I know that some of you are on the register and some of you know that I have recommended this because it is a means by which you can get prosecution instructions. I was recently contacted by Jim Shingler who manages the register and asked if I could recommend any forensic child and adolescent psychiatrists as there are none on the register. I am not sure that I have any on this mailing list but some of you will know some. Obviously it would good to have some on the NCA register and if you are one or you can recommend any, I know that Jim would be pleased to here from you. He knows that I am putting out this notice. His email is: Jim.Shingler@nca.gov.uk

Duties of prosecution experts

Discussion in my medicolegal peer group of the judge's ruling in *Grusza* prompted one member to ask how a prosecution expert should set out their 'unused' material. I had to point out that this was a topic which I covered in the October bulletin but as he/she is probably not the only one who did not read that section and because this ruling is going to prompt many of you to review your approach when instructed by the prosecution, I am copying and pasting here the section from the October bulletin with some expansion:

Obeying the rules

I often comment on how common it is to read an expert report in a criminal case which ends with the a declaration of compliance with the Civil Procedure Rules Part 35 and the wrong statement of truth. Also it is not uncommon to read a prosecution expert's report in a criminal case that does not include the extra declarations required under the Criminal Procedure and Investigations Act 1996, as amended, which include a declaration confirming that you have read and followed the guidance contained in *Disclosure: Experts' Evidence and Unused Material* and recognise the continuing nature of your responsibilities of disclosure. Although the on-line appendices to my book (Appendices 13 and 14) can be downloaded and adapted, I need to draw your attention to the fact that, too late to include reference in the book, the CPS *Disclosure: Experts' Evidence and Unused Material* was updated in 2019 (https://www.cps.gov.uk/legal-guidance/cps-guidance-experts-disclosure-unused-material-and-case-management) with some significant changes.

There is now a requirement that "Upon receipt of instructions you are required to complete a self-certificate (the Certificate) in every case that you are instructed as an expert witness for the Prosecution. The completed Certificate should be sent to the disclosure officer or investigating officer." Hitherto I thought it sufficient to include the declaration in the report. I attach a template (but you must read the guidance as well).

It is also worth looking at 'Appendix A: Experts index of unused material'. I refer to this in brief on p. 91 in the book. So far I have not used the template at Appendix A and have opted for a simpler addition to the appendix in which I set out what I now call the 'Documents, materials and unused material'. This is an example from a recent prosecution report:

Date	Nature of material	Subject	Comments
12.7.21	Email CH to KR	Initial enquiry	Para 1.2
12.7.21	Email KR to CH	Positive response	
12.7.21	Email CH to KR	Acknowledgment	
12.7.21	Email CH to KR	Clarification	

14.7.21	Email CH to KR	Terms of reference	
15.7.21	Email KR to CH	Confirmation that falls within my expertise	
16.7.21	Email CH to KR	Attaching updated Early Investigative Advice	
20.7.21	Email KR to CH	Further confirmation	
20.7.21	Email CH to KR	Agreement to instruct	
20.7.21	Email KR to CH	Address for delivery of disk	SENSITIVE
21.7.21	Email CH to KR	Re delivery of disk	
27.7.1	Email CH to KR	Disk codeword and attaching Schedule of Material	? SENSITIVE (codeword) See Appendix 4
16.8.21	Email KR to CH	Confirming receipt of disk	
16.8.21	Email CH to KR	Acknowledgment	
13.9.21	Email KR to CH	One day delay	
13.9.21	Email CH to KR	Acknowledgment	

If you use my 'File Front Sheet', which is on-line Appendix 5 to my book, it should be easy to compile a table like that above. However, I intend to do some work on the CPS template with a view to producing a simpler version suitable for most prosecution psychiatric reports.

The example above is simply a list of emails but the table can include any documents with which you are provided by the prosecution, or which come into your possession, in addition to the list of documents upon which you have relied.

There is no comparable disclosure obligation if you are instructed by the defence in a criminal case but it is sensible to work on the basis that any communication may be disclosed even though it is legally privileged. I've lost count of how many times my draft reports have been inadvertently disclosed so be aware that anything that you write, or say, in the course of a case may be revealed in evidence and, if you have not been careful, used in cross-examination either to challenge your credibility or your evidence or both.

In a recent case where I was instructed by the defence, I was asked to provide a list of all of the documents with which I had been provided both upon instruction and subsequent to the preparation of my initial report. It comprised the documents listed in my initial report, the

documents listed in my addendum report and a number of documents with which I had been provided after I submitted my addendum report.

Sailing close to the wind

In case you think that what happened in *Grusza* is an isolated case, it is not. I heard of another prosecution expert who was recently cross-examined up hill and down dale because he/she had not complied with Part 19 of the Criminal Procedure Rules, who had not got his/her examination notes with him/her when asked in court to refer to them and who then provided the court and the parties with the notes relating to a different case. He/she was cross-examined by the same defence counsel as in the *Grusza* case but he/she is fortunate that she did not invite the judge to make any sort of ruling.

Fancy sitting on the bench?

The Committee on Experts in the Family Justice System has been working on arrangements that enable experts to sit on the bench with judges in family cases in order to get experience of the whole family court process. They call this a 'mini-pupillage' as it is modelled on the system that enables would-be barristers to get work experience in barristers' chambers. When pupil barristers get the same experience of sitting with a judge they are sometimes called judges' marshals.

I did not have this experience when I was training but I can imagine that it is quite invaluable and I have previously suggested that training scheme organisers should make contact with their local resident judge so that speciality registrars can get this experience.

The FJC sees its mini-pupillage scheme as a means of familiarising potential experts with the family justice process, demystifying the role of the expert in the family courts and hopefully dispelling some of the myths. If you have trainees, I suggest that you consider taking advantage of the system. But even if you are not a trainee, you might yourself value the experience. I attach a form which can be completed and sent to the FJC's central office. Staff there will then put the applicant in touch with the appropriate local judge.

This is yet another FJC initiative which is of wider application so let it be a prompt especially to forensic trainers to give your specialty registrars this experience in the criminal courts.

Tales from Belmarsh

I am pleased to report that for the first time I have got into Belmarsh Prison without being sent back to the Visitors' Centre. My record is being sent back seven times and on that occasion when the

interpreter and I finally got through security we were informed that the prisoner had refused to see us.

On my previous visit I was sent back twice and one of the reasons was that there was a tear in the lining of my jacket which is not surprising as I usually wear my oldest suit when I go to prison. So do check your clothes carefully when you dress for a prison visit.

A more serious learning point was this. I managed not to meet up with my interpreter outside the prison and eventually decided to make a start without him as I was concerned that a knock on the door might terminate the consultation prematurely. I assumed that he would be sent through to catch up with me. Not so. I was informed that he was only allowed to enter the prison with me. So I offered to go back through security and fetch him from the Visitors' Centre. That I was told would not work as I would not be allowed in a second time! So, if you need an interpreter at Belmarsh, do make sure that you meet up and go in together.

Good wishes,

Keith

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