The views expressed on these pages do not necessarily reflect the views of RCPsych.

JANUARY 2022

Recent judgments

The recently added judgments begin with *Thorvaldsen v Dundee City Council* which is a personal injury case involving somatoform disorder. Next are three judgments of general relevance mainly touching on issues of independence and impartiality: *Freeman v Pennine Acute Hospitals NHS Trust, Original Beauty Technology Co. Ltd v G4K Fashion Ltd and Tehrani v Hamilton Bonaduz AG*. Then we come to the judgment in the *Assange* case where you will see that my evidence was considered inadmissible. The judgment makes a number of points about the duty of the expert and the importance of keeping up to date with changes in procedural rules, in this case being aware of Crim PR r 19.9. Finally there are two judgments from Ireland which illustrate how well-constructed psychiatric reports can be of assistance when the court has to decide if a custodial sentence can be suspended: *Director of Public Prosecutions v O'Connor* [2021] IECA 326 and *Director of Public Prosecutions v RT* [2021] IECA 344. Finally *R v Miller* compares a 37/41 hospital order with a custodial sentence and is probably now one of the most helpful judgments to assist where this issue arises.

'Unused material'

I said previously that having regard to the CPS *Disclosure: Experts' Evidence and Unused Material* which was updated in 2019 (https://www.cps.gov.uk/legal-guidance/cps-guidance-experts-disclosure-unused-material-and-case-management) I would consider further how to produce a list of 'unused material'. I attach three versions of 'Appendix A: Experts index of unused material'. The first is Appendix 1 as set out in the CPS guidance. The second ('amended') shows how I suggest that it can be amended for psychiatric cases. The third ('accepted') is the same as the second with the amendments 'accepted'. The fourth ('example') shows how the form could be completed in a hypothetical psychiatric case.

I was initially puzzled that 'CASE NOTES made at the time of examination' are regarded as 'unused' material. I can now see that although our case notes (i.e. history and examination findings) are 'used' in order to prepare our reports, they are not usually evidence in the case and the purpose of this form is to set out all materials which are not evidence in the case but might become so.

I am going to 'trial' this version of Appendix 1 and I will report in subsequent bulletins any feedback I get.

Family Court news

I have been informing you of development in relation to expert evidence in the family courts and I take this opportunity to attach a copy of the first newsletter that has been produced by Mr Justice Williams who is chair of the Family Justice Council Expert Witness Committee.

Redacted medical records

Once again I have been provided with heavily, haphazardly and bizarrely redacted medical records and this is a (redacted!) version of the letter I had to send to my instructing lawyers:

> "These records have been redacted and indeed redacted in such a bizarre way that I find it difficult to believe that the person who carried out the redaction had any idea what they were doing. Would you please arrange for me to have either a set of unredacted records or a set in which the redactions are no more than data protection and privacy laws and regulations require.

“The main issue that I have to address in this case is the defendant's fitness to plead and stand trial. This requires a consideration of his thought processes. However, it appears that some entries that have a bearing on this matter have had words redacted. Whether he is found unfit to plead and stand trial or convicted it will be necessary to consider the risk he poses to the public. Entries that have a bearing on this have been redacted. Furthermore, whole entries have been redacted ….. and of course I have no idea what information they contain which might have a bearing on the issues I have to consider.

“As it happens, I have been able to work out what some of the missing words are. The word 'mental' seems to have been consistently redacted throughout …. similarly the word 'psychiatric' (and similar) has been redacted …'Psychotic' also seems consistently to have been redacted although not entirely. Another word that has been redacted seems to be 'police' … So also have words related to crime …

“Some of the redactions in the correspondence are laughable: "***** Suffolk is commissioned by Ipswich & East and West Suffolk Clinical Commissioning Groups"; "Suffolk Young People's ***** Project"; redaction of the dialling code for Hellesdon Hospital (but not on all of the similar letters) … In some documents his NHS number has been redacted but not in others.

“What is the point of these redactions: … "[Personal] history", "[Forensic] history", "[Psychiatric] history", "[Discharge] Letter", "A young *** with a well established history ... "?

“I have to try to guess clinical details [examples] … Of course I can tell from the context that some of these are not relevant but that is not so for all of them.

“There are other bizarre redactions in correspondence, including preprinted parts, and on forms and records: "ask any questions to address any **** that you may have about your health"; "telephone number shown at the ***** of this letter"; … redaction of hospital telephone numbers; "Bury St Edmunds **** Station"; "Working together for better ***** health"; "Chief **** Michael Scott"; "If you **** received this fax in error please notify the sender"; "you are hereby notified that any **** distribution or copying of this fax is prohibited"; "Drayton **** Road"; "**** Headquarters"; "West Suffolk ****"; "***** ***** and Social Care Directorate"; "Suffolk ****** ****** Partnership NHS Trust; "(Please ***** with a tick)"; "Bury St *******"; … "St ****** Hospital"; "Quantity or duration of ****"; "This column has been ***** for doctors to enter A, V or C at their discretion" (the redacted word is 'provided'); "THIS RECORD IS THE PROPERTY OF THE SECRETARY OF STATE FOR ***** ******"; "Trust Headquarters, ***** Hall Lane".

“A 'sick note' has been redacted!: "If SSP cannot be paid or your SSP is ending your **** will give you form SSP1 to claim social security **** .... If you are claiming social security ***** for any other reason ... Please use **** CAPITALS .... I agree that my doctor may **** the Department for Work and Pensions".

“I should say that these are only examples.

“Although many of the redactions are haphazard and irrelevant, there seems to have been a deliberate effort to obscure the defendant's history of drug misuse and to conceal the fact that he has been prescribed X.

> "As an expert in psychiatry, regulated by the GMC and owing a duty to the court, I ought to be trusted with the clinical information that has been redacted from these records. I should not be hindered in my efforts to understand the defendant's thinking processes and to assess the risk that he poses to the public.
>
> "If I had received these records on April 1, I would not have taken the redactions so seriously. But for the fact that it would have been a breach of data protection law, I thought of using the records for a Christmas quiz along the lines of that part of *The News Quiz* in which the teams have to fill in the missing words.
>
> "I should not make light of this matter. If these records have been redacted by a member of the general practice staff, I hope that this person is not responsible for triaging requests for appointments with the doctors. It has been suggested to me that there are computer programmes for redacting medical records. If that is so, I find this even more worrying in case the company responsible for creating the computer programme wins a contract to provide artificial intelligence software to the arms industry."

A query

I have received this email:

Ideally one would get one report at a time, see the client, digest the instructions, dictate the report, edit the report and then send it off.

The reality is very different and involves juggling multiple clients, solicitor requests and short deadlines!

Can you give some advice about how you would ideally recommend structuring ones medicolegal work?

I appreciate things never quite go to plan but it would be useful to have an ideal / efficient working template in mind.

Do you assess multiple clients simultaneously and then work on the reports in parallel or do you have a more linear approach (ie one report at a time)?

I replied:

When I was doing several cases a week, most involving live assessments:

Work up each case in advance, reading, assimilation of medical records, witness statements into report template, so I would have several worked up ready to see them.

See them, often 2-4 consecutively in a single clinic, perhaps an outlier or 2 elsewhere in the week, e.g. in prison.

Do the reports in order of appearance, finish one before starting the next.

The only exception to this would be perhaps starting a very lengthy negligence report and breaking off a couple of times to keep the others moving.

Now:

I do only 2 – 4 cases a month so even easier to keep them separate but for various reasons completing a report on A may be done in between working up B and assessing C.

Beware doing similar cases in parallel ….

Courses etc

The EWI is offering:

Pain & Medico Legal Workshop

11th February 2022

9.15 AM to 4.45 PM

Speakers: Dr Hannah Bashforth, Dr Mark Alexander-Williams and Dr Wael Agur

Location: Liverpool

Pain presentations in personal injury cases: psychological and medical factors.

Our second workshop, taking place in Liverpool, once again brings together experts from the psychology and medical worlds with a common interest – to explore issues related to pain within the medico legal context. Speakers will meet as a panel at the end of the day to answer questions from the delegates.

Here are some more EWI courses: **https://www.ewi.org.uk/Training-and-Events**

This is the link for Academy of Experts courses: **https://academyofexperts.org/training/**

Another question and my answer

"I'm a forensic consultant in and have been a consultant for 4 years. Although I did many reports as a trainee and enjoyed it, for various reasons including mat leave and busy jobs, I've done very few as a consultant. I think it's also happened to be the case, by chance, few have come up in my day-to-day work. I'm essentially interested in doing more medico-legal work but feel cautious about it given lack of recent experience of reports. Wondered if you had any advice in demonstrating expertise. Obviously, I've completed all that is required in training but it's a matter of recent practical experience. Would it be reasonable to have the first couple supervised? In practice I'm not sure how that would be documented in a report, or if it was, I'm not sure it would be reassuring to a court! Perhaps it is simply enough to have completed training and have done many reports, albeit not for a while and i just feel cautious as I'm out of practice.

My reply:

> "An expert witness should never be anything but cautious, however experienced they are. But, as you did many reports as a trainee, I suspect that you are being over-cautious and attaching too much importance to recent practical experience. The moment you start to work on your next case, you will quickly overcome that out of practice feeling. You are fortunate to have done many reports when you were in training and that means that you are already more experienced than those consultants who do their first expert report after becoming a consultant.
>
> "How do you demonstrate expertise? The core elements of your ordinary clinical CV transposed and translated into a one-page medicolegal CV will be sufficient to demonstrate your expertise as a forensic psychiatrist. You demonstrate your expertise both as an expert witness and as a forensic psychiatrist in the form and content of your expert report and, if the report on its own is not enough to resolve the issues, your meetings or conferences with the legal team, your responses to further questions or requests for amendments and, if the expert issues are not resolved by the time of the trial, your oral testimony. You need to have only one demonstrably good report in the hands of a specialist criminal barrister to find that you are recommended to other solicitors.
>
> "As a result of the *Pinkus* case, supervision is a difficult matter. If you are instructed as the expert, your instructing solicitors will expect that it is your expertise that they are purchasing so to discover that you are working under supervision will come as a surprise and if you refer to supervision in your negotiation of instructions it will not be surprising if the solicitors turn away and say that it is not in their client's interests to rely on an expert who has to be supervised. You have probably seen the reference to *Pinkus* on page 80 in the book but I attach the *Pinkus* judgment and suggest that you read paragraph 24 carefully. A *supervisor* is going to do exactly what the judge lists in the middle of that paragraph. You can get another expert to act as a *proof reader* and deal, for example, with formatting and syntax but I don't think it is that about which you are asking. An expert acting as a proof reader will be able to point out, for example, that the reasoning underlying a particular opinion needs improving and want to suggest that you include reference to facts A and B but if they do so they will cease to be just a *proof reader* and become a *supervisor*. Perhaps they can ask: 'Are there other facts on which you can rely better to substantiate that opinion?' Then you have to go back and discover or recognise the relevance of facts A and B.
>
> "Again, as you did so many reports as a trainee, I suggest that you simply get back into expert work as quickly as possible and as soon as your first case has concluded get your report(s) and any joint statement peer-reviewed. You ought to be in a medicolegal peer group in which this could be organised but if not I am willing to peer-review a report for you. It seems that you have done some reports as a consultant. Get your last report peer-reviewed.
>
> "You have not asked about getting instructions after your break. I suggest that you write to all of the solicitors for whom you prepared reports as a trainee or who acted for defendants in cases where you were instructed by the prosecution. Getting prosecution instructions can be difficult as in many cases these result from the officers in the cases, on the instructions of the CPS, getting two or three names from the National Crime Agency's expert list and, with the exception of C&A experts, the NCA considers that it has as many psychiatrists on the list as it needs. Do you have a particular area of expertise for which experts are in short supply

> and which might justify your name being added to the list? I am not sure if you want to get instructions in civil cases. My first instructions in a civil case came from a firm for which I had done a number of criminal reports and my name was obviously passed from one solicitor/department to another. If you are writing to firms which know you from when you were a trainee, look at their websites and if they have a personal injury department, mention in your letter that you will accept instructions in personal injury cases.

FEBRUARY 2022

Recent judgments

Ever since the *Jones v Kaney* judgment in 2011 many experts have feared being sued. The last judgment, *Radia v Marks*, in the attachment of judgments, is such a case. The recently added judgments begin with *R v Nijhavan* which I suggest is essential reading if you have a case in which SSRI antidepressants may be implicated in the causation of suicidal or homicidal thoughts. The case of *S* is helpful if you have a case involving what appears to be a vulnerable witness. There is the usual case of experts not abiding by the rules, the case of *Cox*. *Palmer v Mantas* is this month's 'mind your language' case.

Short form reports

I have only reluctantly prepared 'short' or 'screening' reports for the NHSLA or the solicitors who act for the NHS in negligence cases. I have always insisted on being provided with sufficient records properly to evaluate the case and insisted on explaining fully my reasons. I have not been instructed many times in such cases. Often the bottom line has been 'This case is indefensible – make an early offer to settle'. I suspect that this is not what they want to hear and so I am not instructed again until someone new is in post who is unaware of my last such opinion.

I can now attach a paper co-authored by Anton van Dellen, barrister and ex-neurosurgeon, whose RSM expert witness training I did in 2018 and which I commend to you when it is offered again. Anton says that we should simply not do these reports.

Redacted records

Two of you responded:

> I couldn't resist replying to say I have had exactly the same problem with redacted GP notes with the same words removed. I wonder if they have a list - no doubt the list consists almost entirely of words we would be interested in like crime, police, prison, assault, mental, psychotic etc. Sometimes I have seen them remove words such a wife, mother, father etc. They seem to search for these words and remove them irrespective of the context. I haven't complained yet as, like you say, you can usually figure what they are.

Danny Allen confirmed that the culprit is the software or perhaps more correctly the person who wrote it so I am right to be afraid that they might get the contract for the software to be used in military robots.

They clearly use software to remove all references deemed sensitive and this is nonsense. We have added a line to our standard letters:

> We require **unredacted** records. Standard redaction software deliberately removes all reference to mental ill health and this is clearly not appropriate.

Thanks to Danny Allen for the latter.

Top three pieces of medicolegal advice

Prompted by his reading of Richard Reed's *If I Could Tell You Just One Thing*, Yameen Qureshi has asked me what would be my top three pieces of legal advice. I throw this open to you all. Next month I will answer his question and collate your answers if you have time to respond.

Consultation on 'Fixed recoverable costs in lower value clinical negligence claims'

You might want to consider responding to this consultation https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1051227/Fixed-recoverable-costs-in-lower-value-clinical-negligence-claims-a-consultation.pdf which closes on 24 April 2022.

I have done so, suggesting that psychiatric negligence claims should be excluded. This is because even in low value cases the volume of records can be huge and so the lawyers, with a budget of only £5000, will not be able to obtain truly expert opinion. Just as the Legal Aid Agency's derisory rates have led many experts not to undertake criminal cases funded by the LAA, I think that these proposals, if implemented, will drive away psychiatric experts from many clinical negligence claims which, albeit of low value, ought to be properly investigated.

An expert colleague who works in the care field has suggested that the solution is not to include the costs of the expert evidence in the £5000.

Joint report by Her Majesty's Inspectorates of Constabulary, Prisons, and Probation (A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders - HMICFRS (justiceinspectorates.gov.uk).

Readers of the *BMJ* will probably have noticed the editorial *Journal* (https://www.bmj.com/content/376/bmj-2021-069776.full?ijkey=BNcnLfzCYmrWH77&keytype=ref) by Charlie Brooker and Jeremy Coid 'Mental health services are failing the criminal justice system' and subtitled 'A national review is urgently needed to reverse the decline'. It is written in response to the HMI report and it makes for disappointing reading.

The editorial includes a reference to how there is insufficient attention to mental health in court reports and indeed cases where no reports are provided. So those of you who do provide psychiatric reports to the courts are fulfilling an important role.

MARCH 2022

Recent cases

The newly added cases begin with *AAD,* a human trafficking case. Next is *Bullman*, an extradition case. *Skillett* shows how psychiatric evidence was rolled out in a testamentary capacity case. *Tredget* was for me a walk down memory lane, an appeal going back to fitness to be interviewed under The Judges' Rules that came before the 1984 Police and Criminal Evidence Act. If you do psychiatric negligence cases, I suggest that you read *Traylor* in full. I do not recall seeing a case report of a

successful psychiatric negligence claim. Of course many such cases settle without going to trial but as with other reported cases this one illustrates how difficult it is to win a psychiatric negligence case if it goes to trial. *White* is essential reading if you do police pension cases, particular where there is an injury on duty issue. Bear in mind that the judge found the 2006 Regulations wrong in one place and suggested that they should be withdrawn. *Q* is a sad case of refusal to accept medical treatment and although there are a number of reported cases relating to anorexia nervosa, this one is different as Q had bulimia and the critical matter was the risk associated with her hypokalaemia. But this deals also with litigation capacity. I had not heard of notification orders under the Counter-Terrorism Act until I read *Bary* so if you get such a case, this is essential reading.

British Academy of Forensic Sciences 'Neuroscience and the Law' 14 May 2022

I attach details of this one day meeting which I encourage you to attend. Nigel Eastman was a BAFS Council member and he has been influential in the planning of this meeting. You can, I hope, register through this link: https://bafs.org.uk/index.php/events/register-for-bafs-event/neuroscience-law

Top three pieces of medicolegal advice

Prompted by his reading of Richard Reed's *If I Could Tell You Just One Thing*, Yameen Qureshi asked me what would be my top three pieces of legal advice. I deferred answering for a month to see what you might suggest. None of you have responded so here is my answer:

1. Get training as an expert witness
2. Be fiercely independent
3. Update your training frequently

Templates

One of you has asked "do you have a particular 'template' you use when describing Bolitho/Bolam. e.g, for my fitness to plead /M'Naghten, I have some standard copied and pasted preamble setting out my criteria, and a set format I use when giving my opinion." What I do is to set out extracts from those two cases and / or, in a report for Scotland, from *Hunter v Hanley* (see Box 2.5, page 25 in my book). I see that I have not referred to an Irish case which I recall predates *Bolam* and to which you should also have regard in a case for the jurisdiction of Ireland. I will try to locate this case. I am puzzled that I did not include it.

Fitness to plead and stand trial in Jersey

It is embarrassing but unsurprising to have to point out that the book misrepresents the law on fitness to plead and stand trial in Jersey. If you read the preface you will see that we did not manage to get a consulting editor from Jersey. A recent case has brought this to my attention. FTP in Jersey has been, since 2016, covered by statute law:

The Mental Health (Jersey) Law 2016 provides at section 57:

57 Determining issue of incapacity

(1) The court determining an issue as to the defendant's incapacity shall have regard (so far as each of the following factors is relevant in the particular case) to the ability of the defendant –

(a) to understand the nature of the proceedings so as to be able to instruct his or her lawyer and to make a proper defence;

(b) to understand the nature and substance of the evidence;

(c) to give evidence on his or her own behalf;

(d) to make rational decisions in relation to his or her participation in the proceedings (including entering any plea) which reflect true and informed choices on his or her part.

(2) The issue as to the defendant's incapacity shall be determined on the balance of probabilities.

(3) For the purpose of determining the issue of incapacity –

(a) the court must obtain, and have regard to, medical evidence on that issue; and

(b) the court shall have all such powers to make orders in respect of the defendant under this Part as it has in respect of a defendant under Articles 61(1) and 62(1).

(4) Where the court determines that the defendant is incapable but considers that the defendant's incapacity might be alleviated by special measures to enable the defendant to participate effectively in the proceedings –

(a) the court shall have regard to whether it is practicable to put in place such special measures; and

(b) if the court considers it is practicable to do so, shall direct that such special measures are put in place.

Amendments to reports

I have had the following question:

> The issue is regarding amendment requests. I was approached by a solicitor requesting amendments to a piece of work I completed 2 months earlier. I was fine with most of the amendments requested but they also sent a 30-page document which was not sent to me initially. This has created a huge discomfort for me as I am concerned there might be some information within the document that could upset the piece of work I had earlier submitted.
>
> Is there an acceptable approach to dealing with this? I am still a relatively new expert witness. I do not want to come across as unreasonable but also worried I might set precedence for similar issues in the future if I do not handle this properly. Can solicitors send new documents after we complete reports and if so, is there an acceptable time frame for this and any amendment requests?

I replied:

First, have you looked at the section on 'Amendments' in the second edition of my book? Please note an error in the quotation from John Maynard Keynes. It illustrates how easy it is to make an error by quoting someone else's quotation without checking the original. What he actually said was, 'When the facts change, I change my mind'. So this is my introduction to your question about what to do when provided with a 30-page document that might contain information that could affect the report you have already prepared.

Your opinion is fluid. It must be open to modification throughout the litigation process, up to and including not just cross-examination but the very end of oral testimony when the judge has the opportunity to ask you questions. Indeed, your opinion may change after the case has concluded and such could surface in an appeal.
So those 30 pages may or may not affect your opinion. You are obliged to consider this new information. It was refusal to do so, until he was in the witness box, which was one of the reasons why the psychiatric expert got into so much trouble in *Phillips v Symes*.

What is important is that if you change your opinion, there is a document which explains in sufficient detail why you have done so. This may be an amended version of the original report or an addendum to it. Either way it needs to be clear when you received the additional information which has led to the change of opinion. So, if you are amending your original report, when you list the documents and materials considered, list those which you received prior to the preparation of the original report and list under a separate heading those received since you prepared it (and including the date on which you received the additional document(s)). My interpretation of para 55 of the *Guidance for the Instruction of Experts in Civil Claims* is that, at least in civil cases, it should be clear from your report when you received particular documents and materials.

What is also important is that, if you know that your report has been disclosed to the adverse party and / or the court, you are under an obligation to ensure that your change of opinion is disclosed to the court. Of course you ought to be able to rely on your instructing party to do so but not always. I was instructed in a criminal appeal where the issue was the appellant's fitness to plead and stand trial. Within a couple of weeks of the date of the appeal I was provided with information which caused me to conclude that, contrary to the opinion I had already expressed, I was of the opinion that he had been fit to plead and stand trial. Application for leave to appeal had been based on my original report. The Criminal Procedure Rules (19.2(3)(c)) require the expert "to inform all parties and the court if the expert's opinion changes from that contained in a report served as evidence or given in a statement". As the hearing was only a few days away by the time I completed my addendum report, I sent a copy to the Lord Chief Justice and got an earful from defence counsel who was very cross that I had scuppered her client's chances of a successful appeal against his conviction. That for me was preferable to getting an earful, or worse, from the Lord Chief Justice (who was hearing a batch of fitness to plead appeals) when in the course of my oral testimony I explained that I had changed my opinion.

Your reference to the length of the additional document makes me think that you may be concerned also about the time it takes to consider and respond to this additional information. It will take you time and you should be able to charge for it. Your terms and conditions should have made it clear that the fee for the report does not include any additional work dealing with, for example, amendments necessitated by the disclosure of further evidence.

So, to answer your question, 'Can solicitors send new documents after we complete reports and if so, is there an acceptable time frame for this and any amendment requests?', yes, they can. As to an acceptable time frame, usually you should be in a position to provide your amended opinion within two to four working weeks. If you cannot do so, particularly if you are sent a huge volume of documents, such as medical records, negotiate a date with your instructing lawyers.

ICD-11

The same correspondent asked:

> The solicitor is also asking me to apply the ICD-11 criteria in my report. I saw the client last year and the ICD-11 only became active in January 2022 (as far as I'm aware). I intend to decline this request but it got me wondering if we must now use the ICD-11 in all future reports. I still do not have access to the diagnostic criteria for research (DCR-11) which I would usually include in the appendix section of my work.

I replied:

I am reminded that one of you contacted me several weeks ago asking if I knew how they could get a print version of ICD-11. I think that I did not reply. In any event, I did not know the answer. I am now prompted to deal with this.

I have just spent some time trying to find the ICD-11 mental disorder guidelines on line. The WHO website gives the impression that the actual guidelines are readily available. Not so, or so it seems. However I ask the question, I cannot find the actual guidelines. Of course one has to be careful about Wikipedia but eventually I found this:

Aside from the updates made for the ICD-11, the WHO has developed an ICD-11 subset of the *Clinical descriptions and diagnostic guidelines* (CDDG), although it has not yet been published.[29] A book of the same name was released in 1992[30] for the ICD-10, which was also known as the "Blue Book". It contains expanded definitions and diagnostic criteria for the mental disorders, whereas the ICD-10/-11 mental disorders chapters contain only short summaries. The ICD chapters are meant as a quick reference point, whereas the CDDG is meant for extensive diagnosing by health care professionals. To differentiate the old and the new version, the newest revision is called the ICD-11 CDDG. The WHO described the development of the ICD-11 CDDG as "the most global, multilingual, multidisciplinary and participative revision process ever implemented for a classification of mental disorders", involving nearly 15,000 clinicians from 155 countries.[27] As of February 2022, the WHO has not made the ICD-11 CDDG publicly available.

It therefore appears that the ICD-11 equivalent of 'the blue book', *Clinical Descriptions and Diagnostic Guidelines (CDDG) for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders*, has not been published and is not even available to the public. If correct, this may be the answer to the request from your instructing solicitors. It is interesting that this request has been made. Although there have been cases where the courts have eschewed reliance on ICD and DSM, there are circumstances in which experts are expected to apply ICD or DSM if they can. An example, with which I have been dealing this week, is police pension cases and where I have prefaced my ICD-10 diagnoses by stating:

I am advised that the Applicant's condition should, if possible, be described by reference to the ICD or DSM. I will disregard the DSM which was developed in the USA to assist in the classification and validation of health insurance claims and which is now heavily influenced by the interests of the pharmaceutical industry and lobby groups. The ICD is more widely accepted but it also has its limitations. Its descriptions and guidelines do not pretend to be comprehensive statements about the current state of knowledge of mental disorders. They are simply a set of symptoms and comments agreed, by a large number of advisors and consultant in many different countries, to be a reasonable basis for defining the limits of categories in the classification of mental disorders.

In 2018, anticipating that in an historical child abuse case, where my diagnosis of complex post-traumatic stress disorder had been challenged by the adverse party's expert on the basis that it was not in ICD-10 and that ICD-11 was not due to be introduced until 2022, I included in an amended or updated report an appendix on ICD and DSM. I have previously circulated you with a copy. My own view is that some courts and tribunals accord ICD and DSM a status and authority which in the medicolegal context they do not deserve or at least deserve unreservedly. I admire Professor Michael Kopelman, in the Assange case, for daring to refer to them, in his oral testimony, as "those bloody books".

You might want to ask, simply out of interest, why you need to apply ICD-11 criteria and you might also ask if your instructing solicitors can direct you to where you can obtain a copy of *Clinical Descriptions and Diagnostic Guidelines (CDDG) for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders*.

I will be interested to hear if others have experience of using ICD-11 in reports or know how to get the seemingly unpublished CDDG. I have written to the College asking if there is a College ICD-11 person who can update us but I have not had a reply.

Covid and medical negligence

One of you wrote asking for my views (either directly or through one of the monthly newsletters) on where Trusts stand in relation to negligence vs COVID19. The correspondent says that they have approached this by saying 'in a non-pandemic world, this is the standard of care I would expect etc...', but ultimately left it up to the Court to decide. I am asked if I have been instructed on any clinical negligence cases relating to standards of care that overlap with the pandemic yet or discussed with anyone who has. This was my reply:

This is an interesting question. I am dealing with some clinical negligence cases that have occurred during the pandemic and Covid has not been mentioned in the instructions. However, altered practices, in response to Covid, which were clearly in existence, have not been an issue so far.

My first thought is that the standard of care has not been changed by the pandemic. Therefore in assisting the court when it decides about a breach of duty, the pandemic makes no difference.

My impression, simply based on press reports, is that there are negligence cases going forward and in which it will be alleged that the causative failures were failures which would not have occurred but for the pandemic. This rather suggests that it can be assumed that there has been no acceptance of lower standards resulting from the effects of the pandemic. Of course it will be a while before any such cases come to trial but I can say that so far I have not seen any judgments in which this has been an issue.

I have reminded myself of *R v North and East Devon Health Authority, ex. p. Coughlan* (2001] QB 213 where Lord Woolf, having regard to the National Health Service Act 2006, as amended, ss 1 and 3, said:

> The truth is that, while the Secretary of State has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable.

Note that the statutory duty is to *promote* rather than *provide* a comprehensive health service. If, as a result of the pandemic, it has not been possible to provide as comprehensive a (mental) health service as was provided pre-pandemic, it would seem that the pandemic has made no difference in terms of the Secretary of State's statutory duty under the NHS Act.

There is also the case of *Re HIV Haemophiliac Litigation* [1998] 41 BMLR 171 where Rougier J held that it was plain that Parliament did not intend there to be a cause of action for any member of the public affected by breach of the duties in the Act.

In contrast, the MHA, s 117(2) places a rather more specific obligation on health authorities to *provide* aftercare services for a class of patients with mental disorder. However, when the Court of Appeal had to consider this in the case of *Clunis v Camden and Islington Health Authority* [1998] QB 978, it rejected Clunis's claim that the health authority might be liable for breach of the statutory duty to provide him with appropriate aftercare services. Beldam J held that "the wording of the section is not apposite to create a private law cause of action for failure to carry out duties under the statute".

Either way, it appears to me that we continue to apply the *Bolam* and *Bolitho* tests disregarding any possible effects of the pandemic on the provision of healthcare. It will be a matter for the courts to decide whether or not any breach of duty, admitted or proved by reference to the *Bolam*/*Bolitho* standards, is actionable. However, I had not previously appreciated the significance of s 117(2) in the context of clinical negligence litigation. I am minded therefore to distinguish carefully failures to make appropriate provision in accordance with s 117(2) in order that, if it is necessary to do so, the court can distinguish such failures from any other failures to provide care to the *Bolam/Bolitho* standard.

Redacted records

This is the latest instalment in my now long-running saga. In one case the solicitor obtained an order from the court for disclosure of unredacted records. When I was sent the 'unredacted' records they were anything but unredacted. There were over 65 redacted entries which included the names of medication prescribed since I had assessed the defendant and details of to whom or where he had been referred for further treatment. My response was to write to the judge in the following terms:

> Under CrimPR 19.2(1)(b)(iii) I have a duty actively to assist the court in fulfilling its duty of case management under r 3.2, in particular by at once informing the court of any significant failure to take any step required by a direction. It appears to me that there may have been such a failure on the part of the ***** Surgery to provide me with unredacted copies of the Defendant's medical records in response to a witness summons issued on 21 January 2022 and the purpose of which I understood was to meet my needs as an expert witness under r 3.2(2)(b).

Perhaps next month there will be another instalment.

Validity tests

I had this query:

> Might it be possible to have a brief chat/correspond about part of your book? Pages 216/217; 'Psychological testing may include symptom validity tests, tests with internal symptom validity indicators and tests of effort and malingering, but performance may be influenced by memory impairment, dementia, education, IQ and age. Psychological

> expertise is necessary to interpret such tests results. Leave to the psychologist the tests which only they are qualified to administer, score, interpret and defend in cross-examination.'
>
> I accept that for many psychiatrists training in stand-alone symptom/performance validity tests is unusual. I found myself wondering what suitable training would look like. The APA at its annual meeting runs workshops and symposia on ML reports, exaggeration and assessment on a regular basis, I am unaware if AAPL do so too. PDP groups with neuropsychologists are another route to keeping up to date on developments.
>
> I found myself wondering that whilst I would entirely agree with 'Leave to the psychologist the tests which only they are qualified to administer, score, interpret …', absent ongoing administration of, and practice with, scales using embedded validity tests, eg MMPI (vX), PAI and similar multi-scale systems, the free-standing ones should be within reach of the competent psychiatrist; which I think was suggested by Tracy in Advances. Or in other words, with training and supervision it is no longer 'only they [who] are qualified'.
>
> One particularly useful textbook is *Validity Assessment In Clinical Neuropsychological Practice. Evaluating And Managing Noncredible Performance*. Editors RW Schroeder And PK Martin, Guilford Press, New York/London 2022. The European (Biennial) Conference on SVTs would be useful, when it restarts.

I responded with an email and spoke to the correspondent later in the day. This was my email response;

> In short, the sort of training you describe probably meets the requirements but whatever training an expert has received in X, Y or Z, they have to be prepared for a challenge to their expertise by a cross-examiner seeking to devalue the training: too long ago, the reputation of the training company/trainer, unfavourable comparison with the training undertaken by the adverse party's expert, etc.
>
> There are tests which psychiatrists can be trained to administer but I think that there remain a (? Small) number of tests which can only be administered by registered users who are psychologists.

Certificates of peer group attendance

A member of my medicolegal peer group asked: what about Peer Group CPD certificates? We do not issue them and I could not resist replying:

If the peer group does produce certificates of our peer group attendances, I suggest that they are embossed in gold, signed by all members, in gilt-edged frames and at least 50 cm high and 30 cm wide. It will prompt me to have a new wing built to the house where I can display my CPD certificates. They will be of enormous interest to our family, friends and visitors. More importantly, if the RCPsych CPD bean counters have cause to query my CPD submission they can come and stay locally, at the expense of course of the Royal College of Psychiatrists (which means paid from our membership fees and, if they have to increase, at least it is a tax deductible expense), and peruse the gallery at their leisure.

APRIL 2022

Recent judgments

In the judgments attachment, this month's judgments begin with an extradition case, *O'Donnell*, reminding us that there is a high threshold to be reached to prove that suicide risk is so high as to make it oppressive to extradite a requested person. As happens when waiting for a bus, two come along at once, so this month there is another case of alleged psychiatric negligence, *Williams*, again illustrating how difficult it is to prove psychiatric negligence at trial. *R v BRM* is important reading if you have a criminal case involving autism spectrum disorder. The case of *Smith* should be reassuring for experts who have little or no experience of giving oral evidence and are concerned that they will be compared unfavourably with a more experienced expert. For me the *Keal* case is of particular interest as I have written on the subject of moral wrongfulness in the insanity defence and the message seems clear that if the law of insanity is to be amended, it will be Parliament and not the courts. *Hughes* is another testamentary capacity case which illustrates a number of important points about the assessment of testamentary capacity. Although *HU027662019* concerns expert social work evidence, it sets out quite plainly some basic points about expert evidence. I hesitated about including *Re B (A Child), Adequacy of Reasons)* but I think experts might write more judge-friendly reports if they understand the process that a judge goes through in setting out a judgment. Finally I also hesitated about including *North Yorkshire Clinical Commissioning Group* as the points seem so obvious but it is probably worth restating them.

The *Williams* case reminded me how much psychiatric practice has changed since I was a junior trainee. The court decided that there was no question of Mr Williams going to the psychiatric unit for assessment. It had to be the accident and emergency department. The psychiatric unit was not set up to provide such assessments. I recall a weekend as duty psychiatrist at the Royal Edinburgh Hospital in about 1977. Patients did attend there for assessment and they waited in an area of the Andrew Duncan Clinic opposite the hospital's telephone exchange. The corridor from the 'acute' end of the hospital to the 'long stay' end passed between the telephone exchange and the waiting area. Aware that I had about a dozen patients waiting for assessment, I had to get from one of the acute wards to a medical emergency in the longstay area without running the gauntlet of the patients and families in the waiting area, so I climbed out of a groundfloor window and ran round the back of the hospital to get to the longstay ward. How times have changed.

International Conference: Neuroscience and the Law, Gray's Inn, London,

I attach again details of the British Academy of Forensic Sciences conference on 'Neuroscience and the Law'. There are some outstanding speakers. Those of you who have attended the Grange Conference will recall the fascinating presentation by Lord Hughes and Professor Ronnie Mackay is also a previous Grange Conference speaker. You can book at [Upcoming BAFS Events]

The 21st Grange Annual Conference, Ripley Castle, North Yorkshire, 27 – 29 September 2022

We have almost completely finalised the programme for this year's Grange Conference. You can find it here https://www.educationandtrainingnetwork.co.uk/wp-content/uploads/2022/03/Programme-as-at-17March22-website.pdf and you can book the conference at https://www.educationandtrainingnetwork.co.uk/the-21st-annual-grange-conference/ There are bursaries for trainees.

Taxation on income from cases in Ireland

If you engage in expert witness work in Ireland it is likely that you will be taxed in Ireland and of course you will also have to declare the income to HMRC. I did a case in Dublin in December 2019 and have probably now spent more time emailing the Revenue department in Ireland than I spent giving evidence in court. In order to claim back the tax deducted in Ireland, you need a TC1 form from the Revenue Department in Ireland and you have to get a letter from HMRC confirming your UK tax status. I have finally had the tax refunded this week. The first lengthy delay was in getting the appropriate letter from HMRC. One problem was that I gave as my address on the TC1 form my professional address but the form was not accepted because the address did not match the address on the letter from HMRC (my home address and the only address HMRC has for me).

Redacted records (continued)

Last month I mentioned a case in which the court had ordered disclosure to me of unredacted medical records and those provided were redacted (although not as heavily redacted as the first set). I have now heard from the court on behalf of the judge who "has noted your observations and fully understands your concerns. She has directed the Court to fix a hearing date for trial Counsel to attend and this is hoped to be towards the end of April." I should have the next instalment next month.

The reluctant defendant

I had a query this month which is pasted here with my response in red type:

I was asked by the prosecution to examine a person on remand in prison. I was initially asked to establish presence of any mental disorder and treatment order etc. I saw him at prison twice and after initial reluctance he agreed to see me for assessment. Although initially reluctant, you will have either concluded that he had capacity and assessed and reported on him on that basis or concluded that he did not have capacity and reported your findings in his best interests and in the interests of justice (they overlap).

More recently I was asked again to establish fitness to plead matters. I again visited him in prison and on this occasion he declined to see me and could not be persuaded.

Prior to visiting for assessments at prison when requested by prosecution, I inform the prison healthcare arranging my visit. Depending on the state of mind of the prisoner verbal agreement is taken for the examination. Written confirmation may also be taken but this may not always be possible in the disturbed patient in prison.

RCPsych CR 209 (2017) gives some guidance on reporting to court where there is concern about presence of mental disorder or of unfitness to plead. CR 209 says the expert would be duty bound to report back to the court.

In such a situation can the expert be alleged to have made an assessment of the prisoner without adequate agreement? As you are reporting his refusal to be assessed, you are not reporting an assessment as such. If you did not set eyes on him because he refused to attend, (1) it is entirely appropriate that the prosecution/court should know this and (2) you may, on the basis of your previous assessment, of which they are aware, consider it appropriate to suggest that his refusal might be more likely a consequence of the mental disorder previously identified (if you did) rather than a simple unwillingness to cooperate with the criminal proceedings. If you saw him then you can consider yourself as having assessed him at least in terms of a mental state examination. So again, (1), it's appropriate to inform the court. Then (2) it appears to me to be in his interests to say what

you found on examination. If you had reason to suspect or confidently diagnose mental disorder it is in his interests that this is addressed as otherwise justice for him will be complicated and/or delayed. If you conclude that his refusal had nothing to do with mental disorder it is also in his interests for the court to know that he is not cooperating with the criminal justice process as, without knowing this, the court will be uncertain as to how to proceed and this will mean that justice for him is delayed (as also for any complainant and witnesses).

I do not see that you can withhold from those instructing you the fact of his refusal to see you. If you saw him and thought that he had signs of mental disorder, it is in his interests and the interests of justice to give a qualified opinion to that effect. If you saw him and thought that he had no mental disorder, it would not be in the interests of justice to conceal this information and it would not be in his interests for the justice personnel, including his own legal representatives, to be left uncertain as to whether or not you thought you had detected any mental disorder.

Committee on Experts in the Family Justice System, Spring Newsletter

I attach the Spring Newsletter prepared by Mr Justice David Williams.

Questions from solicitors

I have had this enquiry from a psychologist:

I have some questions from the Claimant's side, who I was instructed by. I want to ask if I am okay to reply directly or if it should be disclosed to both sides.

I replied:

> Your instructing party can ask whatever they like to clarify your opinion or to get answers to questions which they have belatedly decided need to be answered. You reply to them directly and you do not copy your answers to the other party's solicitors.
>
> If your report has not been disclosed, they may decide to disclose your letter with your report or they may come back to you and ask for you to incorporate your answers in a consolidated report for disclosure. You could respond more formally and set out your answers in the form of an addendum. Either way, it is important that your response includes the questions. Each one can be a heading. What you must not do is simply answer Q1, Q2 etc as your answer only makes sense when read with the question.
>
> If your report has been disclosed and in answering one or more of the questions you find that an opinion expressed in your report has changed, then you must inform the adverse party and the court without delay. In such a circumstance, do a separate letter to your instructing solicitors explaining the change of opinion and how it has come about and send a copy of it to the other party and to the court. If you do not have the details of the adverse party or the court, include a sentence: 'I realise that I do not have the adverse party's details/name of the court and case number, so would you please send a copy of this letter to the adverse party/the court without delay because, as you are aware, when an expert changes an opinion following disclosure of their report, they must inform the adverse party and the court.'

Make sure that you keep a note of how long it takes to answer the questions and invoice your instructing solicitors for the extra work. This should be covered by the terms and conditions which you should have agreed with your instructing solicitors on instruction.

Questions posed by your instructing solicitors are to be distinguished from what are called Part 35 questions which are questions put by the adverse party upon receipt of your report. There is a section on 'Answers to Questions' pp 95 – 96 in my book Rix, K., Mynors-Wallis, L. & Craven, C. (eds) *Rix's Expert Psychiatric Evidence*, 2nd ed. 366 pp. Cambridge: Cambridge University Press, 2021. The title is slightly misleading. There are generic chapters which are relevant to all expert witnesses or healthcare expert witnesses. Much of the content of the specialist chapters is as relevant to psychologists as to psychiatrists.

The correspondent came back with two further questions:

I have two further questions ...
Can I decide to alter my report to accommodate the questions or should the solicitor decide? I think it would be easier.
I have been asked a question I think is nearly impossible to answer (about the number of likely future relapses when a person is living with an ongoing trigger). I would be plucking a figure out of the air. I assume it is okay to explain this and answer the question in a more realistic way?

I replied:

I suggest you telephone them, give them the alternatives but if your preference is to revise your report, be bold and tell them so, nevertheless do what they want.

Prognosis questions are often some of the most difficult. First you must preface your answer by saying that it is nigh on impossible etc (but professionally worded). Then write down the first figure that comes to mind. I often find that this is the nearest I will get to an accurate estimate. Next try to imagine that you are with a group of mental health specialists and decide on a range of reasonable opinion. Answer the question giving your best estimate, indicating what you think the range of reasonable opinion is and point out that if you are wrong, you do not know in which direction or how far wrong within that range. If you can give reasons for your opinion, all the better but on an issue such as this it is often not possible.

CrimPR 19.3

I am in a dialogue with a correspondent about some matters which are largely not to do with expert evidence and this correspondence caused me to look up Crim PR 19.3:

(3) A party who wants to introduce expert evidence otherwise than as admitted fact must—

(d) if another party so requires, give that party a copy of, or a reasonable opportunity to inspect—

(i) a record of any examination, measurement, test or experiment on which the expert's findings and opinion are based, or that were carried out in the course of reaching those findings and opinion, and

(ii) anything on which any such examination, measurement, test or experiment was carried out.

(4) Unless the parties otherwise agree or the court directs, a party may not—

(a)introduce expert evidence if that party has not complied with paragraph (3);

This relates to material created by an expert in the course of their information gathering for the purposes of providing a court with expert evidence of fact or opinion. For a psychiatrist, this means the notes the psychiatrist makes when taking a history and conducting a mental state examination. It may include the form on which you document, for example, a MMSE.

I know some psychiatrists who simply do not know that if asked to disclose those records they are obliged to do so.

Access to or copies of material considered in preparing a report

This came up in the same correspondence;

I am not sure where there is a specific provision in CrimPR but it is well-established in case law that an expert must identify all of the material upon which they have relied in producing their expert report. Opinions can only be tested by the parties and / or the court if they can examine the facts on which the opinions are based.

Any document upon which you rely, including medical records, becomes disclosable once you rely on it. You may see documents on which you do not rely. Arguably in a civil case you are not obliged to identify them but it is good practice to do so and if the adverse party wants to see them, the parties or the court can decide if they should be disclosed. In a criminal case, if instructed by the prosecution you must provide a list of everything you have acquired so that anything upon which you do not rely can be listed as ‘unused material’ and potentially made available to the defence. If instructed by the defence, you must list everything upon which you rely (unless, such as counsel’s advice, a conference note or your letter of instruction) it is legally privileged.

Prosecution expert asking defence expert/patient’s consultant to obtain defendant’s/patient’s permission for access to their medical records

I was also asked about this and replied: In my view this is wrong. The defendant should have given consent for their medical records to be obtained in the course of the investigation. Sometimes the police obtain permission at a very early stage. Sometimes defence solicitors obtain their client’s permission and then they obtain copies of the records. As the treating consultant you should only be involved in this if there is an issue as to your patient’s capacity to consent to the release of their medical records.

Lying behind this there is, I suspect, a lack of central or top-level guidance as to procedure and a variety of practices which may vary from one police area to another.

When I am instructed by the defence, usually I do not make my assessment until I have been provided with copies of the general practitioner records at least. I rely on my instructing solicitors obtaining copies. It must be many years since I used my own consent form to obtain general practitioner or mental health records.

When I am instructed by the prosecution I ask the prosecution for the medical records. In many cases they have already been obtained by the police and they accompany the MG5 and other prosecution material. In one case recently, where the defence expert had quoted from the psychiatric records, I asked the CPS to obtain the records and they said that they would not do so and it was up to me to get the records. They had passed my request to the defence solicitors, who

did not have copies, and I was advised to get them from the defence expert. But he did not have copies. He worked for the NHS trust in which the defendant had been treated so he simply accessed them through his own trust's records system. I was then advised to seek access from the trust's records department. To my surprise they were sent as a bundle of electronic files quite promptly but the problem was that they did not send me exactly the same records as the defence psychiatrist had perused.

In your case it appears that an order was made for the disclosure of the defendant's records. This ought not to have been necessary. Consent should have existed somewhere for both the prosecution and defence experts to have access to the defendant's medical records.

Perhaps what is needed is a standard consent form which, once completed by a defendant who has capacity, is sufficient for a general practice, NHS trust or independent hospital, to release copies of the defendant's medical records to medical experts whether instructed by the prosecution or the defence. It should then be possible to create an electronic bundle which is available to any or all experts.

There are two related considerations.

The GDPR and the DPA 2018 allow the sharing of personal data, where it is necessary and proportionate, with law enforcement authorities who are discharging their statutory law enforcement functions. If this means that the material does not have to be redacted (my Ipswich case may shed light on this), then the form should refer to, and emphasise, that the request is for unredacted records (and if possible include some authoritative reference).

The other consideration is the selectivity of the disclosure by the records departments. In a recent case I found the process incredibly complex and it took from May to November to get the hospital records. In the meantime I was asked which records I wanted. My request for all of the records was insufficient but without knowing the categories I was unable to provide a list of all the categories. It was only following the second or third request that I got the day to day multiprofessional record. That critical piece of information, on which an opinion can turn, could be anywhere in the records.

This is an aspect that I think requires a high level discussion between the Law Society, the CPS, NHS England and the College of Policing and / or the National Police Cgiefs Council (and possibly even the Information Commissioner).

MAY 2022

Recent judgments

This month I have found only three judgments that I think it is worthwhile bringing to your attention. In the attachment they start with *Commscope Technologies LLC v SOLiD Technologies, Inc*. This is the usual judgment in which the judge compares the approaches of two adverse experts and then explains why they prefer the evidence of one over the other. *Mathieu v Hinds* is a good illustration of how the courts approach evidence based on medical and scientific research and will be of value to those of you who report in cases of traumatic brain injury. *M (A Child : Private Law Children Proceedings: Case Management: Intimate Images)* is an excellent example of how a psychology expert assisted the court in deciding what special measures are going to be needed for a vulnerable witness, it sets out in considerable and fascinating detail how the psychopathology of complex post-

traumatic stress disorder can affect a witness and it includes a very comprehensive exposition of the guidance on vulnerable witnesses and special measures.

Think before you click!

The risks of clicking on a link have been very much in the news this weekend. Last week I was in an online meeting and noticed an email arrive relating to a case in which I had done a report. I ignored it until the meeting finished and then discovered that I was expected in a Crown Court hearing and was instructed to click on the link. I did have it in my diary but it was crossed out and my recollection was that the CPS had said that the issue in question was being postponed to a later hearing. Not wanting to get into trouble and the more so for keeping the court waiting, I immediately clicked on the link and found myself talking to the judge. For some reason I had lost the visual connection and could not see her which was quite disconcerting. So I was not sure if she could see me, but she said that she could. I immediately apologised for being improperly dressed (casual shirt and sweater but also properly dressed below waist for once) and unprepared (and was conscious that I had not covered with a dust sheet those medical and legal textbooks which would have allowed counsel to play the game 'My expert's got more books than your expert' or invited them to ask questions about my model Napoleonic war ambulance and stretcher party). She and counsel were as surprised as I was to be beamed into her courtroom. They were not expecting me as I had indeed been stood down but no one had informed the court usher who had sent me the link. We had a brief discussion about delays in listing cases. She referred to the item on that morning's *Today* programme. She then asked me for my availability and a trial which had been listed for 23 May 2022 is now in my diary for 15 May 2023! Justice delayed ….

Insanity defence

I have recently had this query and my response is in red.

> I wonder if i could ask you for your expertise or perhaps point me in the direction of a recent judgement about not guilty by reason of insanity verdict based on the person acting on an insane delusion . The judges in *M'Naghten's case* were asked: If a person under an insane delusion as to existing facts, commits an offence in consequence thereof, is he thereby excused? The majority (Maule J dissenting) replied: "To which question the answer must of course depend on the nature of the delusion: but, making the same assumption as we did before, namely, that he labours under such partial delusion only, and is not in other respects insane, we think he must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real. For example, if under the influence of his delusion he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defence, he would be exempt from punishment. If his delusion was that the deceased had inflicted a serious injury to his character and fortune, and he killed him in revenge for such supposed injury, he would be liable to punishment." I have underlined for emphasis. So, I think you say, suppose what he believes is true, would a normal person in those circumstances consider it right or wrong to do what he/she did? (I think we ought to include this 'rule' in the 3rd edition.)
>
> I had a couple a cases recently where the accused have known what they are doing and had an awareness that it was wrong but believed their life was in danger so this sounds like self-defence where the law is quite clear that the accused cannot rely on self-defence – see p. 127 in the book and 'the reasonable lunatic'; but that's not the same as saying that they do not have a defence of insanity because, if their life was in danger would they be judged to

> have done wrong in reacting as they did or they had to do it to escape I think similar, it would depend whether what they did in order to escape would have been reasonable (? proportionate). They had delusional beliefs that people were trying to harm and kill them so see above or were acting on behalf of the devil now here I think they don't have a defence of insanity if you accept that in general the devil personifies evil so if you know you are acting on his (but like God, he could be female) behalf then you know that you are doing wrong. This is to be contrasted with an agricultural labourer charged with the theft of barley, oats and rye from a farm who believes that he is a werewolf because werewolves are not servants of the Devil but rather God's hounds and so he should be allowed the defence on the basis that by doing what werewolves do, and battling against the forces of Hell to bring back from there ("a place of abundance … where the riches of the land above – grain, fish, fruit and meat – were brought after being stolen by sorcerers") such riches of the land to ensure the prosperity of his village, he believes that he is doing right and not wrong (see *Old Thiess, A Livonian Werewolf: A Classic Case in Comparative Perspective* by Carlo Ginzburg and Bruce Lincoln, 2020, Chicago).
>
> On number of occasions i have a opined that they have been not guilty by reason of insanity based on them acting on an insane delusion but other psychiatrists have not agreed and judges seem to take a lot of persuasion preferring to stick to the original wording of the mcnaughten rules.

I prefaced the above comments with:

> It's difficult to comment definitively without all of the facts of these cases. As the appeal court judges so often say, cases are fact-specific (which to my mind means 'We'll decide it how we like and not be bound by what has happened in other cases').
>
> I think the only significant insanity judgment, since the book went to press, has been *R v Keal* [2022] EWCA Crim 341 (which I circulated last month) but the issue there was not knowledge of nature and quality or knowledge of wrongfulness but compulsion to act on the delusion.

Getting paid for work in Ireland

This month I have finally had refunded the tax deduced by the Revenue Department in Ireland for a case in which I gave evidence in 2019. Needless to say it was without interest.

I have an ongoing case there and my instructing solicitor has drawn this guidance to my attention: [Expert Witness Fees Procedures and Guidelines Document - LAB (legalaidboard.ie)]

My solicitor in that case also advised me that if you give evidence in court in Ireland it is important to get your LA3 form signed by a court officer before you leave court.

One of my Irish correspondents has also advised this:

> With legal aid I send the invoice and LA5 form with the report. So payment then arrives. It MUST be the original of the invoice and LA5 and the invoice must have a reference number. So no scanned signatures or email to send them. Some solicitors great about that and sending off the bills to Tralee, Co. Kerry where they are processed. Others need to be nagged.

Feedback and appraisals

I have had this query recently:

I am completing an appraisal with ****** and then due for revalidation.

I completed a 270 ACP feedback through the college which included solicitors and then received the following from the appraiser:

> *I was unsure of the position with regard to patient feedback in your case given the nature of your interaction with patients and so asked **** for some advice.*
>
> *This is their reply:*
>
>> *'My understanding from the appraisal form is that the doctor examines patients in her capacity as a medicolegal doctor. If this is the case then they will need to obtain formal patient feedback through a recognised provider. Some providers require smaller numbers of respondents eg Equiniti and Edgcumbe. *** may also be able to accept an abbreviated patient report from some providers if insufficient patient numbers are able to be obtained.*
>>
>> *If the doctor does not examine patients as a medicolegal doctor then the appraisee should contact me to request an exemption from formal patient feedback.*
>
> *I realise that this is going to present a challenge and we can discuss this further at our meeting.*
>
> *I can assure you that **** is very supportive and very experienced in situations where patient feedback is difficult to obtain.*

I carry out assessments in the Family Court where parents may have harmed their children and I cannot see how it is possible to ask for feedback - I think it may affect the necessary impartiality.

I note that you do not ask for this in the new MAEP - perhaps I should have registered for this but it felt unfamiliar and so did the usual.

Do you have any ideas?

I replied:

For at least ten years I have had it in mind to create a version of 'patient feedback' which could be used for the subjects of reports. It was higher up the in-tray when I devised MAEP but I have still not got round to doing this. Some colleagues have used a modified patient feedback version. When I get back I will look out what I have and what little I have done.

But the real issue is whether or not this should be a requirement. I have never been asked to produce it, either by the appraisers I had outside the NHS and organised through our Grange appraisal system, even though they were appraisers who themselves did medicolegal work,

> or any of the three appraisers I have had through NSFT now that my appraisals are done in the NHS.
>
> I have had no patient feedback for some years. I used to give out the forms when I did MHA assessments or sent them to the ward in those cases which were admitted but I think no more than one was ever returned and my new appraiser sees no point in giving them out to patients assessed under the MHA.
>
> I suppose what has held me back is the problem of the subjects of reports not understanding the expert's duty to the court or simply disregarding it if the opinion is not to their liking. And related to this would be the likelihood that disagreement with the expert opinion would lead to the subject perceiving the behaviour of the expert unfavourably even if on some of the parameters on objective grounds there would be no cause for complaint.
>
> I think you should use MAEP. I have found it very helpful both in demonstrating the necessary skills and attributes but also getting suggestions for improvement which the anonymous feedback facilitates.
>
> My only other thought is that you could try challenging the requirement on the basis that the subjects of reports are not patients and so patient questionnaires are not suitable. The problem however may be that there is an overlap between the duties of a doctor to a patient and the duties of a doctor to the subject of a medicolegal report. However, if you are using MAEP and getting feedback from solicitors, and particularly if you seek feedback from the adverse party's solicitors, you can argue that your (high) scores for professionalism will have taken into account your approach to the subjects of the reports. In the family context, the solicitors acting for the parent(s) will have regard to any feedback they get from the parent(s) and being themselves professional will distinguish between genuine adverse feedback and feedback driven by their client'(s') disagreement with your opinion/evidence.

I would be interested to hear how many of you are required for your appraisal to produce feedback from the subjects of your medicolegal reports.

I take this opportunity to remind you about MAEP and how it can provide the evidence that your appraiser needs in their appraisal of the medicolegal component of you practice as a doctor: https://www.rcpsych.ac.uk/improving-care/ccqi/multi-source-feedback/maep

JUNE 2022

Your safety and security

Having just come across my Certificate of Anonymous Registration in the Register of Electors for ******, I am prompted to inform those of you who do not know that you can apply to have an anonymous entry in your local register of electors. As two men who threatened me with death when released following life sentences for murder are probably eligible now for release on life licence and as my former next door neighbour's property was set on fire by an arsonist who followed me home you will appreciate why I go to such lengths to try and keep my home address secret. See also p. 67 in the book.

This month's judgments

This month's judgments, of which there are seven, start with *Pal v Damen* which makes some general points about the role of the expert witness. The case of *HA* makes for a long read but it covers a number of important points and not least the need to be 'even-handed' and fair when setting out those aspects of your experience over and above your basic qualifications and training. I do not like naming and shaming experts but it would not be possible to anonymise this judgment without omitting a great deal of information that establishes the error into which the expert fell and I know many of you are talking about this case already. *MTT* and *Begum* are two asylum cases, one successful and one unsuccessful but with different learning points. *DPP v FN* has an interesting discussion about motive and intent. The *MORA* case has a simple message: stick to the issue(s). I have included *DPP v Abdi* because it includes an analysis by a supreme court judge of the role of a psychiatrist who reports on a defendant in a criminal case. The judgments in *DPP v FN* and *DPP v Abdi* were both delivered by The Hon Peter Charleton, Justice of the Supreme Court, Ireland, who will be giving one of the judicial lectures at this year's Grange Conference so do come and hear what he has to say (https://www.educationandtrainingnetwork.co.uk/the-21st-annual-grange-conference/).

More on the rise of artificial unintelligence

In my latest case where I have been sent redacted medical records, I found the following redaction:

I refer to above patient who is due to be sentenced in ***** to a road traffic incident this month. In advance of the sentencing Hearing, we have arranged for a ***** to prepare a report to comment on his ***** health.

This was from the letter sent by my instructing solicitors requesting the copies of the general practitioner records. Needless to say these were not the only redactions. Am I not allowed to know that I am a psychiatrist?!

I have asked the solicitors to get an order from the court for the disclosure of unredacted records.

Am I the only one fighting this battle? Please do let me know. I am contemplating raising this with the Lord Chief Justice.

Experts of the Month

As you know, it's unfortunately easy each month to find judgments that name experts who have failed in their duty to the court, or worse, and, in the case of medical experts who may be known to you, I usually try to avoid naming and shaming. I have no such reservations about bringing to your attention psychiatrists and psychologists who have had positive comments so, this month,

In *Brittain v Ferster* [2022] EWHC 1060 (Ch) "Dr Jarman's evidence was careful and measured."

In *HA (Expert evidence; Mental health) Sri Lanka* [2022] UKUT 00111 (IAC) Professor Greenberg was found to be "an impressive witness" and "apart from one inconsistency", his "written and oral evidence was cogent, detailed, consistent and balanced."

A query from one of you

I have had this query from one of you and I prefaced my annotated response to the query with this: But do bear in mind that you have to be careful about asking advice in an ongoing case: look up the *Pinkus* judgment in the book and also *R v Pabon* which is also relevant.

There is a section in your book about the V*ulnerable Defendant* which is related to my query. I was instructed by defence solicitors who are acting on behalf of a young woman … (with a) reported history of domestic violence … I was asked to comment on whether her ability to give evidence will be affected by being in close proximity in the dock with her ex-partner and co-defendant and what special measures could be adopted to mitigate this … I am thinking what sorts of issues that I need to think about that will help the court in this case and also, how to achieve the right balance between supporting her without causing bias towards her co-defendant? The courts make a distinction between vulnerable witnesses (which obviously includes complainants) and vulnerable defendants and my impression is that they are more willing to accommodate the needs of witnesses than defendants but as judges seem to have a wide discretion, if there's a special measure for a vulnerable witness that you think would assist a vulnerable defendant, you can point it out and explain that you acknowledge that ultimately it is for the court to decide what special measures, if any, should be adopted. Do read my summary of *M (A Child : Private Law Children Proceedings: Case Management: Intimate Images)* [2022] EWHC 986 (Fam) because there may well be similarities with your case and also because it is the most comprehensive statement of the law and procedure relating to vulnerable witnesses of which I am aware. Your point about balance and bias is interesting. But you are instructed only in relation to the young woman and not her partner. I think that you can suggest whatever measures you think will benefit her and disregard their implications for her co-defendant on the basis that decisions about special measures will be made at a 'ground rules hearing' at which her c-defendant is represented and if any measure that you propose might be disadvantageous to him, his counsel will be able to point that out to the judge, the judge can then hear argument from both counsel and then the judge can decide having regard to the need to achieve fairness and justice for both defendants.

On the same theme of the V*ulnerable Defendant,* I read with interest your section on *Duress, Coercion and Compulsion*. Is this principle related to my query above? This section may be relevant if you are providing evidence that can be adduced in support of a plea of not guilty. I think that whether or not there is anything relevant in that section would depend on what part she says that the partner had if she admits that she did (do what is alleged). But have you been asked about this as an issue? Elsewhere in the book, I advise you not to address issues that you have not been asked to address. If you have not been asked to address this aspect, check with the solicitor and be guided by them, perhaps with more detailed and helpful instructions.

Also, I was instructed a few times by solicitors who wanted me to comment on the same under the Modern Slavery Act for someone …. I find the information in Box 7.25 helpful as I am struggling to be clear on what is meant by *characteristics* and *reasonable firmness.* The way I interpreted it is that someone's clinical presentation … have likely made them more vulnerable to perceived threats compared to someone who does not share their background and in light of this, the court may wish to decide whether they are vulnerable to coercion, pressure, or intimidation. Be careful. The defence of duress and the defence under the MSA, s 45 are not the same but clearly they are related. You as an expert can say that, for example, a person's post-traumatic stress disorder, which makes them less able to resist the compulsion to do something (assuming that is so in the case in point), would appear to you to amount to 'relevant characteristics', but I think better to refer to those *features* of post-traumatic stress disorder as the 'characteristics' rather than the post-traumatic stress disorder (or whatever the disorder is) itself, and then leave it for the court to decide whether or not to allow

evidence to be admitted as to those 'characteristics' (being mindful that the court might refuse the admission of that evidence on the basis of the objective test as applied to duress – but if it does, there might be grounds for appeal, and so this area of the law may be developed).

Post-traumatic stress disorder and head injury

Question

Can I ask a quick question re PTSD please?
I'm coming across an increasing number of cases where the claimant has amnesia relating to the index event (e.g., falling and hitting their head or car accidents etc..).
Though I've seen some experts take a very strict approach with ICD-10 down to the full stops, I have found myself a little confused.
By virtue of being unable to remember the IE, the claimant(s) do not experience flashbacks / ruminations / etc... per se, but will experience other psychopathology (avoidance, and all of the 'D' criteria within ICD-10).

Have you (/ others you've spoken to), come across this, and if so, what is your stance?

My answer:

If you had been at the BAFS Conference on Saturday you would have heard Chris Frith (brilliant presentation) give the history of this controversy and knock firmly on the head the notion that if you have a head injury with amnesia then you can't have post-traumatic stress disorder. Just because the memories cannot be retrieved it does not mean that none were laid down and of course it is the experience, before the memory is created, which causes the other psychopathology.

Feedback from the subjects of reports

As a result of a query I mentioned last month, I went into my in-tray, which is like an archaeological dig or geological strata, and towards the bottom I found the attached questionnaire. Does anyone recognise it or can anyone direct me to the source please? I am having discussions soon with the RCPsych's new business manager about MAEP and I would like to work out a way of making MAEP 360 degree feedback by including subject feedback.

Last month's correspondent has had a further communication from their appraiser and my comments are in red below:

> The GMC has mandated that every doctor who wishes to be revalidated and who has contact with patients/clients must undertake a multi-source feedback, including the patient/client strand. This is applicable regardless of whether patients/clients are seen once or briefly and also applies to medicolegal doctors. I did not know this. You may find it helpful to know that the GMC has put together a number of case studies that show real examples of how doctors in non-conventional roles have managed to collect patient feedback. These can be accessed via the following link https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/revalidation-resources#revalidation-patient-case-studies. I'm not happy about the concept of a 'medico-legal doctor' but the case study is apposite. Getting the feedback form completed before the subject has seen the report is very important. In the example, the doctor adapts a form for use. So, my draft adaptation that I sent can be regarded as an example of such a form.

> The GMC guidance clearly sets out ways in which the administration of the feedback can ensure client anonymity is protected; the collation of completed forms must not involve you as the doctor, your appraiser or your Responsible Officer. I suppose if I was going to do this, and it looks as though I may have to do so, until the RCPsych sets up a system as part of or in conjunction with MAEP, it would have to be my former PA who gives out the questionniares. The feedback is given anonymously and the doctor shouldn't know which individual clients respond to the request for feedback (it is not mandatory for each client to respond). The doctor sees the results once they are collated into the final report by the external survey company. But which companies at present have systems for getting feedback in medicolegal cases? It is not clear who did the collation for the GMC's medico-legal doctor in the case study.
>
> The *** has considerable experience of medicolegal doctors obtaining patient/client feedback. Although I appreciate your concerns about requesting this in your role, I would advise that the feedback is obtained as soon as possible after the meeting. It may be necessary for the solicitor to send/e mail out the feedback form. I feel that waiting until the end of the case could affect the feedback and the patient/client's memory of the doctor/patient meeting.
>
> Please be reassured that we can accept an abbreviated patient/client report in support of your revalidation if you are unable to achieve the numbers required for a full report. I understand CFEP surveys (https://www.cfepsurveys.co.uk/) request a minimum of 7 responses in order to generate an abbreviated report. This company produces surveys for a range of professionals. It does not produce one for medicolegal consultations so I assume that to use this company it would be necessary to commission it to create what it calls a 'bespoke' survey. Some other providers e.g. Equiniti or Edgcumbe require a low number of respondents. In order to meet revalidation requirements your patient/colleague reports must have been reflected on and discussed with your appraiser at a subsequent appraisal and this must be documented as part of the appraisal summary.

One option that is available to me nearer the time of your revalidation is to request a deferral of your revalidation to allow time to collect the formal patient feedback. Please be assured that a deferral is an entirely neutral act. The formal patient feedback will need to be presented in an appraisal prior to your deferred revalidation date. I think you will have to accept this proposal, create a feedback form and get it into the hands of your next 4 – 7 subjects and hope that a sufficient number respond. In the meantime, when I have a meeting next month to talk about the future of MAEP, I will make out a case for developing a subject feedback arm to the process

A Medicolegal Special Interest Group

Dr Giuseppe Spoto has written suggesting that there should be established within the College a Medicolegal Special Interest Group. I attach his proposal. If you are a psychiatrist and this would have your support please let him know. It would be helpful if you would copy your replies to me so that I can indicate the extent of the support from all of you as a group. I have about 200 psychiatrists on this mailing list (along with about 30 psychologists).

Fitness to participate in extradition proceedings

If you are instructed in extradition proceedings in Ireland, be aware that the Irish High Court is not concerned with the question of whether the defendant is fit to be tried for the offence(s) in the country that is requesting extradition. The test is <u>not</u> that set out in Ireland's Criminal Law (Insanity)

Act 2006, s 4(2) (see p. 120 in my book). The test is one set out by the High Court in *Nolan v Carrick* [2013] IEHC 523: it is the defendant's cognitive ability sufficiently to understand with the assistance of such proper explanation from legal advisors and such experts as the nature of the case may require, the issues on which his decision is likely to be necessary, the nature and effect of the decisions made in the course of the litigation, and the consequences of the decisions made by him for the litigation at that time. The test is set out in similar but expanded terms in *Minister for Justice and Equality v. B.H. (No. 2) (ex tempore, 31st July, 2015*): the ability to comprehend what is going on in the proceedings, to make judgments with respect to the various aspects of the proceedings in respect of which his judgment is required and to give appropriate instructions.

As the courts in all of our British isles jurisdictions recognise, this is a capacity issue to which the *Masterman-Lister* judgment is relevant (and codified now in England and Wales in our Mental Capacity Act 2005). So you have to assess the Defendant's ability to (1) receive/understand information, (2) retain it long enough to make a decision, (3) weigh the information to make a decision and (4) communicate the decision.

Critical to this is what it is about which he will have to make decisions in this litigation. Capacity is issue-specific. One issue is loss of his liberty through the process of surrender so the Defendant has to decide whether or not he should surrender. I do not know what other specific issues arise in extradition proceedings. In the circumstances, I therefore think that it is reasonable to ask for examples of the various aspects of the proceedings in respect of which the Defendant's judgment will be needed, the issues on which his decision is likely to be necessary, the nature and possible effects of those decisions made in the course of the litigation and the possible consequences of the decisions. Only when you can put these issues to the Defendant, or less ideally put to him matters of a similar nature and complexity unrelated to the proceedings, will you be able to ascertain his cognitive ability to understand the issues. You cannot assess the Defendant's ability to weigh up information as to the likely consequences of deciding one way or another unless you know what those consequences might be.

I think that this is a good example of the importance of a dialogue with instructing solicitors at the instruction stage so as to ensure that the expert knows exactly what assistance it is that they are providing to the court.

I am not aware of an extradition case in any of the other jurisdictions in the British Isles where the court has had to consider the requested person's capacity to participate in the proceedings. If such as case should arise, I suggest making specific enquiry as to the test to be applied.

JULY 2022

Recent judgments

In the last month there have been eight judgments that I want to draw to your attention. In the attachment, they begin with *Wright v Abbey Equine LTD T/A Abbeyleix Stud Farm* [2022] IEHC 341.

Wright along with *Gallagher v Gallagher (No.2) (Financial Remedies)* [2022] EWFC 53 and *Lidl Great Britain Ltd v Tesco Stores Ltd* [2022] EWHC 1434 (Ch) make fairly basic points of a general nature concerning expert evidence, specifically about impartiality and reasoning, and *Gallagher* also makes some useful points about concurrent expert evidence ('hot-tubbing') of which psychiatrists seem to have little experience (and I have none).

There are two cases concerning capacity, and jurisdiction specific, *The Public Guardian v RI* [2022] EWCOP 22, which is about capacity to make a lasting power of attorney (in England and Wales) and *CD v BB* [2022] IEHC 381, which is about litigation capacity (in Ireland). But *The Public Guardian* is also important as it discusses the significance for an expert medical witness of their category of specialism on the GMC's specialist register.

There are two deportation/extradition cases, *Minister for Justice & Equality v Damji* [2022] IESC 27 and *JMPS v Secretary of State for the Home Department* [2022] UKAITUR PA018492019. You will know from previous judgments that in extradition and immigration and asylum cases, psychiatrists should not give evidence about the mental healthcare that the requested person is likely to receive in the requesting country unless they have experience of mental healthcare in that country. So *Minister for Justice and Equality v Damji* is of interest because the U.K. was requesting the extradition of Ms. Damji from Ireland and there was an expert in Ireland who was also able to give expert evidence as to the treatment available to prisoners in the U.K. This case is also of significance because in relation to the high threshold that has to be reached for successful resistance of the request for extradition reference is made to the landmark case of *Lauri Love v. The Government of the United States of America* [2018] 1 WLR. The importance of *JMPS* is that it reiterates the importance of cross-checking the requested person's self-reported medical history against what is in their general practitioner records.

Last and certainly not least is *Cloonan v The Health Service Executive* [2022] IECA 129. The focus of this case is the assessment of suicide risk in the context of alleged clinical negligence. It also illustrates how an expert's publications can be used successfully to challenge their expert opinion. It prompts me to remind you about this years' Grange Annual Conference at Ripley Castle from 27 – 29 September 2022 (https://www.educationandtrainingnetwork.co.uk/wp-content/uploads/2022/03/Medicolegal_Conf_22_4March22.pdf) and at which Professor Matthew Large, Professor of Psychiatry, University of Sydney, will be talking about the prediction of suicide.

Subject access to expert reports

Q. I was wondering if you have experience of patients making direct requests for access to reports and information to you (rather than the solicitor/court), and how to manage these?

A lady on whom I completed an independent sentencing report in 2019 has been trying to contact me requesting a copy of the report and all information that I used to prepare it. I have taken advice from [my medical defence organisation] and have asked for her to be directed to her solicitor to provide the report, but she is continuing to ask for my direct details.

Any advice would be much appreciated- I understand she has a right to access this, but I do not feel comfortable liaising with her directly.

A. I have a little experience of this. It has only been requests for a copy of the report itself. Recently a man who was charged with a criminal offence wanted a copy of the report I had prepared many years previously for a personal injury (historic child abuse) case. I have no hesitation in providing a copy but I always point out that it was produced in a particular context, at a particular time and to address specific issues so its relevance in the present circumstance could be questionable.

But you are right to direct her to the solicitors in any event.

I have to say I am uncertain about what your response should be for access to the information that you had in preparing the report. I assume that all of it would have been provided by your instructing solicitors and it would be more straightforward for her to get the report and that information from

their files. I would expect that their 2019 files will not have been destroyed. My guess is, however, that as all of the information that you had relates to her, she is entitled to have access to that information (save for 'third party' information) so I think that it comes down to making her access as easy as possible and with appropriate safeguards.

I will be interested to know what [your medical defence organisation] says.

I must admit that I am uncertain.

Competing cases

Q. I have been asked to provide **non** availability for 3 separate PI cases during the same 3 month window.

I don't actually take on many cases so this is coincidence ?

How do I manage this ?

Apart from a small amount of annual leave I will be available but of course I do fear being double or triple booked !

A. In the days before GDPR I would have sent my commitments list to all three, copied them all in, listed the three cases as potentially falling within the same window and invited them to liaise.

Post GDPR you have to email them individually, explain that there are two other cases vying with their case and ask their permission for you to put them in touch with the others.

Post GDPR I was told that listing a case on my commitments list with the contact details of the instructing solicitors without their permission was a breach of GDPR!

I don't think my PA any longer sends out a commitments list but it should probably now be in the format:

** - ** month year Trial Details can be provided if instructing solicitor gives permission

In the old days solicitor X could contact solicitor Y and they could work out how, usually easily, a double-booking could be managed.

It is also worth noting the utililty of a witness summons. If you have a witness summons in Case B but not in Cases A and C, Case B will take priority. Otherwise, if there is an absolute clash, the higher court will pull rank.

Calling all neuropsychiatrists …

This year I have had three requests to identify neuropsychiatrists who are willing to accept instructions in criminal cases. If you are a neuropsychiatrist who is willing to accept instructions in criminal cases, or if you know of one, please let me know.

I have previously mentioned that the National Crime Agency does not have any child and adolescent psychiatrists on its expert list and I now know that it does not have any neuropschiatrists on the list.

Its list is importance as the police use the list to identify experts who will accept instructions by the prosecution. Regardless of your specialism, being on the NCA list is useful as it means that you can get prosecution as well as defence instructions. In criminal cases you may be asked if you prepare reports for both the prosecution and the defence (just as in a civil case you may be asked about your ratio of claimant/defendant instructions).

Your address

Q. I am just starting out doing reports independently and working from home. I was wondering what address do people put on their reports when they use their home as office. Do I have to put an address on my reports or is it enough for the instructing party to have my email address only?

A. There have always been some experts who don't give any address, phone number or email address which makes it very difficult to contact them.

I was using my ex-PA's new office address but since she has moved entirely to working from home I am sending out reports with no postal address at all and as most communications now are by email this does not seem to matter.

I think you are OK with just email address. Occasionally solicitors will want to post documents and you can then give them your home address on the condition that it is not disclosed to the client, is used only for the specified purpose and is not stored or retained in any IT system.

Danny Allen, in my book, refers to the use of a PO Box address but it seems (surprising to me) that it can lead to your actual address being found and I think it must nowadays be an unnecessary expense.

What may be important is for people to know in which geographical area you consult although with remote assessments now so common that's not so important.

Reporting in family cases

Through the Expert Witness Institute, the following email has come to my attention:

> I am, as I explained a Family magistrate in Somerset but also very involved with a national project called Pause which works intensively with women who have multiple babies taken into care to try and break the cycle. These women often appear in court. The project started in Hackney and is hugely successful and is now in many cities and some rurally deprived areas. Pause has identified a growing problem to do with Expert Witnesses Reports written for this cohort of women.
>
> The Expert parental psychiatric or psychological assessment commissioned by the court making recommendations for the parent`s mental health treatment is not co-ordinated with local provision. This sets up the parent to fail when there is no provision or funding locally which obviously leaves parents in deep despair and the children concerned possibly never able to build or re build a relationship with them. It seems to me a simple professional good practice issue that the Expert writing the report researches the local area for the provision available before making impossible recommendations.

I am involved in the revision of CR193 which will probably become *Code of guidance for psychiatrists who provide expert evidence to courts and tribunals*. It already includes in the section 'Sentencing and medical recommendations' the following:

Liaison with local mental health services

Experts must liaise with local mental health services when making medical recommendations both because the availability of a bed will have to be confirmed and because of the resource implications. Such liaison is also required where consideration is being given to recommending a community order with a mental health or substance misuse treatment requirement. It cannot be assumed that local services will have the necessary community treatment resources and, even if they have, their agreement should be ascertained before the recommendation is made.

Such liaison is particularly important if there is a disagreement about the need for a restriction order given that this will usually require long term treatment in hospital and supervision in the community by mental health services.

I intend either expanding this section to deal with recommendations in family cases or add a similar section in relation to reports in family cases.

Although the concern has been raised in relation to reports in cases in Somerset, I would be surprised if this is not a more widespread problem.

AUGUST 2022

More on addresses

One of you wrote:

On addresses I agree that it's not essential to have one but I use a PO Box as you can see below. It costs around £350 per year. I agree with you I was surprised too when I found out some times ago that your home address linked to it can be discovered, but Ithink it takes more than an internet search and you have to write to the Royal Mail to ask this information

However as you say with most communication now being via email (including instructions and medical records etc) and payments being via BACS the case for having one is less persuasive.

Pause

Last month I mentioned the work of the charity *Pause* and the concerns about experts in family cases making recommendations for treatment without having regard to what the local services might be able to deliver. Sarah Aston, the family magistrate who brought this to my attention, has sent me the attached report *Set Up To Fail*. I do encourage those of you who work in the Family Court to read it and heed it.

Summary of conclusions / Executive summary

I received the following query:

I attended a recent Excellence in Report Writing course hosted by Bond Solon that focused mainly on Personal Injury and Civil claims. I raised the question whether an executive summary was necessary or the current protocol in respect of Forensic reports. I did not receive a clear answer, but something along the lines that judges in Criminal Courts spend far more time reading forensic psychiatric reports

than those in civil Courts. I'd be grateful if you could clarify this matter for me, as my usual practice is not to provide an executive summary.

I replied:

See highlighted below – it's a 'must':

CrimPR Part 19

Content of expert's report

19.4. Where rule 19.3(3) applies, an expert's report must—

(a)give details of the expert's qualifications, relevant experience and accreditation;

(b)give details of any literature or other information which the expert has relied on in making the report;

(c)contain a statement setting out the substance of all facts given to the expert which are material to the opinions expressed in the report, or upon which those opinions are based;

(d)make clear which of the facts stated in the report are within the expert's own knowledge;

(e)where the expert has based an opinion or inference on a representation of fact or opinion made by another person for the purposes of criminal proceedings (for example, as to the outcome of an examination, measurement, test or experiment)—

(i)identify the person who made that representation to the expert,

(ii)give the qualifications, relevant experience and any accreditation of that person, and

(iii)certify that that person had personal knowledge of the matters stated in that representation;

(f)where there is a range of opinion on the matters dealt with in the report—

(i)summarise the range of opinion, and

(ii)give reasons for the expert's own opinion;

(g)if the expert is not able to give an opinion without qualification, state the qualification;

(h)include such information as the court may need to decide whether the expert's opinion is sufficiently reliable to be admissible as evidence;

(i)contain a summary of the conclusions reached;

(j)contain a statement that the expert understands an expert's duty to the court, and has complied and will continue to comply with that duty; and

(k)contain the same declaration of truth as a witness statement.

Section 37 order made without a recommendation?

Q. I wondered if you had ever come across this before? I have had a district judge do an actus reus hearing on a young person who is with me on a section 48/49. He is unfit to plead but only in the door. The judge has then gone on to use the two S48 reports as the medical recommendations to dispose of the case as a section 37.

I have to say I've never come across it before. I've had the standard of disclosures on reports and letter that they can't be used for Court purposes but never thought it necessary for a section 48

A. No, I've never come across it before but the relevant statutory criteria are the same so it is legal. You do not have to use forms for recommendations under Part III. It is sufficient that in your report you use the wording of the statute. As that wording is the same, I don't think that what the judge has done can be challenged. You would I think you only be able to do so if, between admission and the court hearing, he had recovered sufficiently for you to have set in motion a remission to prison, in which case you could say that it was no longer the case that he was suffering …..

I discussed this at my s 12 renewal training. It was pointed out that there is a difference between s 37 and s 48 in that in the case of the latter there has to be an urgent need for treatment. But it does not alter the fact that if they are … mental disorder … nature or degree … appropriate treatment etc according to the s 48 criteria, the court can conclude that they meet the (same) criteria under s 37.

Expert Witness Institute – Certified Expert Witness

The EWI has introduced a new category of membership – Certified Expert Witness:
https://www.ewi.org.uk/certification?utm_campaign=973575_July%20Newsletter&utm_medium=email&utm_source=The%20Expert%20Witness%20Institute&dm_i=5RS7,KV7R,1SFPCV,2K5JD,1

Changes to Parole and Recall Report Recommendations to the Parole Board – Single Secretary of State View

In my medicolegal peer group, our attention was drawn to this document (attached). I commented:

I don't think it's all that controversial as it seems to me that suitability for release can be regarded as the ultimate issue and for the Board to decide and the role of the professionals, like an expert in court and tribunal proceedings, is, other than exceptionally (e.g. DR, some issues in clin neg), to go no further than to provide the facts that enable the Board to make its decision. If anything, it might create a more comfortable position for the professionals. The professional says that if X and Y happen and in the circumstances of Z it is probable that the prisoner will carry out a sexual assault. Whether or not that will happen depends on X, Y and Z. It's for the Board, seized with all of the evidence, to decide how likely it is that X and Y will happen against a background of Z and then the Board decides whether or not to take the risk of releasing the prisoner.

'Don't mention that you have seen this report'

Again in my medicolegal peer group, a member had been sent, in a criminal case, a report on which the defence solicitors did not intend relying and asked the member not to refer to it. I thought that if they relied on any of its content for establishing the facts of the case or forming their opinion, they would have to refer to it. I circulated the group with the following sections from a chapter which I am writing for a book on clinical negligence (and therefore benchmarked against the Civil Procedure Rules and the *Guidance for the Instruction of Experts in Civil Claims*):

Privilege

Where a party elects to take initial advice on the viability of their claim before embarking on the pre action Protocol, the report is protected by legal professional privilege.
Privilege is waved by a party upon the disclosure of a report, whether voluntarily or pursuant to directions, but until then instructions to the expert as well as the report are privileged and the court will not make an order compelling disclosure (*Watts v Oakley* [2006] EWCA Civ 1905). However, earlier drafts of the report remain privileged (*Jackson v Marley Davenport Ltd* [2004] EWCA Civ 1225, [2004] 1 WLR 2926).

The expert's instructions remain privileged but CPR 35.10(3) requires the expert to set out the substance of all material instructions, whether written or oral, on the basis of which the report is written. CPR 35.10(4) states that the court will not order disclosure of those instructions or any specific documents unless it is satisfied that there are reasonable grounds for believing that the statement of instruction in the report is inaccurate or incomplete. Thus, a party who is served with an expert's report is not allowed routinely to call for all of the documents listed in the report. Boyle says that 'any document referred to by the expert on the face of the report is, in effect, disclosed' but the actual test is whether the party on whom the report is served needs the document to understand the expert's opinion or if the expert has used that document as a significant part of the process of forming their opinion. In *Anglia Water Services Ltd v HMRC* [2017] UKFTT 0386 (TC), an expert was criticised for listing in his report only the documents which he considered to be relevant, but the court observed that CPR 35 PD 3.2(2) 'requires details only of material relied upon' (emphasis in the original). The requirement is to set out all material instructions, not the immaterial.

The assumed facts and substance of all material instructions

In compliance with CPR 35 PD 3.2(3), the expert sets out here "the substance of all facts and instructions given to the expert which are material to the opinions expressed in the report or upon which those opinions are based". This section should begin with a recitation of those facts, provided by the instructing party in their letter of instruction, which are of material significance. It is not necessary to set out any facts which are not of material significance but the imperative is transparency and this statement should not be incomplete or otherwise tend to mislead (Guidance, 55). The facts should be recited as they have been received. They may not be accurate and responsibility for any inaccuracy rests with the instructing solicitors. Any significant inaccuracy can be addressed when analysing the facts.

It is important to set out any instructions of material significance which have been communicated or received orally. No instructions are 'off the record'.
Instructions include documents, such as medical records and witness statements, but these are usually listed separately. Instructions include the issues to be addressed and these are set out in a section on their own.

If this section considerably lengthens the body of the report, it may be better to set out only a brief statement and use an additional appendix in which to set out the instructions in full.

Some experts attach to their report a copy of their letter of instruction but it is legally privileged and it should be attached only with the permission of the instructing solicitors. However, if there is reason to believe that the statement required by CPR 35 PD 3.2(3) is inaccurate or incomplete, the court can order disclosure of the letter of instruction and permit cross-examination on the matter.

Documents and materials

This sub-section refers first to the report's Appendix 4 in which are listed at least the 'documents, statements, evidence, information […] which are material to the opinions expressed or upon which those opinions are based' (*B v Nugent Care Society* [2009] EWCA Civ 827, [2010] 1 WLR 516, [2010] 1 FLR 707). It must be accurate. In *Williams v Jervis* [2009] EWHC 1837 (QB), [2009] 7 WLUK 821), the judge imposed a financial penalty on the defendant whose orthopaedic expert was unclear in his evidence as to what medical records, reports and witness statements he had seen prior to writing his report.

Some counsel and solicitors hold that the expert should list all documents and materials with which they have been provided. Others hold that if the expert lists everything, the other side is entitled to see everything and so they should not refer to documents that the instructing solicitors do not intend to disclose for the time being, such as draft witness statements or a report on liability and causation because, if they are listed, the other side will be entitled to see them. What is important is that the expert must not fail to list a document containing information that is relevant to their opinion. If the expert does not list everything, there is the danger that they will include in their report information which could only have come from an undisclosed document which would make them vulnerable in cross-examination. In an application for disclosure of a document or report, the other side will probably succeed if the expert has seen it and relied on it but not if they have seen it, read it and definitely not relied on it. If the expert makes it clear that a particular document is not material to their opinion, it ought to remain privileged. An application for disclosure may succeed if there is some reason to believe that there is something inaccurate or misleading about their statement of the substance of the instructions they have received.

As "instructions" include all materials sent to the expert, the Guidance requires that the list of documents and materials includes the dates on which the materials were received: "The term 'instructions' includes all material that solicitors send to experts. These should be listed, with dates, in the report or an appendix" (Guidance, 55). Where all documents and materials have been provided with the letter of instruction, setting out the date of instruction on the front page should be sufficient. If further documents and materials have been provided subsequently, the date or dates on which they were provided should be made clear in this sub-section or in the appendix.

If documents are missing, illegible or incomplete, the expert should point this out. If the medical records, or other documents, have been redacted, the expert should draw attention to this and make clear that they cannot be held responsible for any misstatement of facts or error of opinion that may be the result of the redaction.
The expert should identify materials that have not been produced with the report such as their own original records of the history they have taken and their examination findings or other professional records. This may include any questionnaires completed by the subject of the report, but good practice is to attach them as an appendix. The expert should be prepared to reveal everything.

Instructing solicitors should be cautious about sending the expert 'background material' and asking them not to refer to it in their report. It may contain information relevant to their opinion and in which case they will have to refer to it. Experts are advised to return such material unread.

If important documents have not been supplied or obtained, the expert should say so, explain why they have not been obtained, indicate why they are important and explain how information from them may make a material difference to their opinion.

If the expert relies on published or unpublished research or other authoritative material, they should say so and cross-refer to the report's Appendix 6, which is a list of references. These will include references to cited work which supports their opinion or the underlying reasoning. It is not a generalised list but the expert can list here any '(r)elevant extracts of literature or any other material which might assist the court' (*B v Nugent Care Society* [2009] EWCA Civ 827, [2010] 1 WLR 516, [2010] 1 FLR 707). In a clinical negligence case in England and Wales, if the expert relies on unpublished work they must provide a copy of it with the report. The expert should supply copies or extracts, with sufficient pages from before and after the extract for it to be seen in context.

NHS Resolution Annual Report

Those of you who do clinical negligence cases may be interested in the attached NHS Resolution Annual Report. Intestingly all of the cases of interest on pp. 40 – 41 have a psychiatric element to them. The secondary victim cases are interesting and we can look forward to an enlightening Supreme Cort judgment. In the meantime, in secondary victim clinical negligence cases, we can see that what is important is to set out a careful chronology so that it can be established exactly when the mind was suddenly and violently agitated as it may make a difference whether it was the allegedly negligent act or the death, that resulted from it, and perhaps after a significant interval of time, that was causative.

Family Justice Council Experts Committee Symposium: The Long and Winding Road, Wednesday 12 October at Birmingham Children's Hospital

Please see the attached notice of this symposium. See you there?

SEPTEMBER 2022

Summary of conclusions/executive summary

Jan Wise has pointed out the difference between a summary and an executive summary:

"I totally agree with the need to provide a summary; I am advised however that an executive summary is rather different and unlikely to deliver to the court what it expects of an expert - an executive summary is far shorter than a summary."

Report for the Parole Board

Q. My Declaration and Statement of Truth at the end has always been for the Court. In case of a Parole Board report, is there a different format that I need to use? Are there different guidelines and regulations there for reports for the Parole Board from the Criminal Procedure Rules?

A. I'm not aware of any equivalent to CrimPR and its PD or to Part 35 of CPR or Part 25 of FPR but you can't go far wrong if you adapt the statement and declaration in the CrimPR PD. Just make sure that it is fully adapted. I can't remember if you have to swear or affirm at a Parole Board Hearing, so just make it 'may' in that bit of the statement, etc.

Not 'Disgusted from Tunbridge Well' but ….

I have deep, deep reservations about the Pause report; and their conclusions about expert recommendations. All criticism of experts and no criticism of NHS Trusts that cut services and professionals so that nothing is offered to people with treatable conditions? Not even NICE recommended treatments?

This was a missed opportunity by Pause and I am disappointed beyond words. I have contacted them to try and get a better understanding of how they came to their conclusion. What would have really helped if they had recommended that the courts have the power to require Trust Leads for psychological Therapies to come and explain why they won't offer a service to men and women who could be treated. Having spent many hours trying to get help for people I see in the courts, it is excruciating to hear that it is apparently my fault that the client I see is not getting help.
Yours in a huff

I truly think this is a clinical resource issue, not an expert issue; the moment the law is mentioned, many clinical services just switch off and refuse to engage. And of course, the prejudice amongst clinicians against people with an EUPD diagnosis is not just a personal issue, some services refuse to offer care to people with this diagnosis at all ('they don't meet our criteria', 'we only treat people with severe mental illness' as if EUPD were not an illness). These are resource decisions being taken at a high level by clinical managers who may or may not have experience of treating people with complex needs; and the problem is compounded by the fact that assessments to access services are generally done by non-psychiatrists with little experience. There is also (of course) a profound stigma about parents who have injured or neglected their children.

I think the College could help by reminding clinicians that mental health services are not just for people with psychosis; and that they are failing in their GMC duty of care if they do not ensure that people with treatable conditions get help. But consultants are pretty powerless when perinatal mental health services (newly commissioned and funded) specifically refuse to help women (a) involved with the family court (b) who have had their new babies removed or (c) have an EUPD diagnosis?

I'm aware that there are some poor experts out there; and I hope I am not one of them. But I actually think that experts insisting on setting out what is needed might actually be the driver of better care, not a hindrance. Parents have their children removed on the grounds of risk to those children and that risk needs to be treated for; and accessing mental health is part of that treatment.

The treating psychiatrist as expert

Several of us have recently engaged in a discussion which I think it is worth sharing with you. It started when I mentioned that this is an issue we are addressing in the revision of CR193.

The first response was this from Trevor Broughton:

On the "treating Psychiatrist" point I'm really so glad this is being looked at. You're also aware of my views that the previous notions of bias have been totally overblown, and I'd see less conflict of interest in preparing a report on one of my own patients (which is really coming from the perspective of having had quite a few cases now where supposed "independent" psychiatrists have made ludicrous recommendations about people I'm looking after). The previous guidance seemed to imply that independence was a sort of bulwark against bias - and I fundamentally disagree with that assumption. I've really gotten into reading around the topic of bias and medical error over the last

2-3 years, going back to the foundational work by Tversky & Kahnemann on the subject, and the notion that an independent psychiatrist would be *less* biased than the treating clinician is just plain wrong in my view. Differently biased perhaps, but certainly not less so. You've probably got a lot of people working on this – and "too many cooks(… etc)" – but I'm happy to add my 2 cents.

Gwen Adshead responded: I very much agree about the 'treating' psychiatrist issue in the forensic context; I think this stems from highly anachronistic ideas about the sacred nature of the clinical encounter, as well as the idea that doctors are always biased in favour of their patients, when it is clear that it may well be the opposite!

I've looked at this again for a chapter I am writing and I copy and paste the section here:

There is also a potential conflict where the treating doctor becomes the medical expert. In *Vernon v Bosley (No. 1)*[1], Thorpe LJ observed that '(i)n the field of psychiatry it may be more difficult for those who have treated the plaintiff to approach the case with true objectivity.' In *A London Borough Council v K*[2] the judge criticised a general practitioner who 'had an unconditional loyalty to the mother repeatedly demonstrated during the investigations leading up to (the) hearing and in his evidence, (who) was irredeemably under her influence, speaking more than once of a "bond of trust" between them.' In *Re B (A Child) (Sexual Abuse: Expert's Report)*[3] the court held it to be 'elementary' that a psychiatrist who was treating the children should not give evidence as an expert in care proceedings on behalf of one of the parents. Former Supreme Court Judge Lord Hughes of Ombersley, in guidance for advocates[4], states: 'The necessary relationship of trust between treating clinicians and their patients may be inconsistent with a duty to the court to provide truly independent evidence'. However, Braithwaite and Waldron[5] point out that 'the treating doctor is likely to know far more about the patient than an outsider who has seen the patient for a few minutes or an hour or two'. In *Doyle v Nagyhabib*[6] instruction of the claimant's physician was permitted and at trial the court observed that it did not see any sign that the fact that he was a treating clinician affected his appraisal.

As Hodgkinson and James[7] comment:

> 'The issue is always one of fact, degree and proportionality but, in general, the more serious and prolonged the symptoms and the treatment regime, the greater the faith that the patient puts in his treating doctors, the more central the doctor is in the treatment regime and the more psychological/psychiatric injuries involved, the less likely the court is to permit a treating doctor to give expert evidence.'

An exception may also be made where it is clear that a claimant does not have litigation capacity, such as where the party is in a coma, minimally conscious or in a persistent vegetative

[1] [1997] 1 All ER 577 CA, [1996] 3 WLUK 473, [1997] RTR 1.
[2] [2009] EWHC 850 (Fam).
[3] [2000] 2 WLUK 784.
[4] Inns of Court College of Advocacy *Guidance on the Preparation, Admission and Examination of Expert Evidence* (2019) The Council of the Inns of Court.
[5] Braithwaite, B. & Waldron, W. *Brain and Spine Injuries: The Fight for Justice* (2010) Exchange Information.
[6] [2021] EWHC 1733 (QB).
[7] Hodgkinson, T. and James, M. *Expert Evidence: Law and Practice*. (2015) (4th edn.) Sweet & Maxwell; p. 185.

state, and expert evidence is needed as to their litigation capacity. In *CS v FB*[8], it was held that evidence from a treating clinician, such as a treating psychiatrist, is all the evidence of lack of litigation capacity which may be necessary and that a letter from a treating doctor confirming the party's condition is sufficient evidence of lack of litigation capacity.

I should point out that this is for a chapter on reports in clinical negligence cases. The criminal jurisdiction, especially in cases where there are sentencing issues, is very much an exception to 'the rule'.

Retention of records

Q. "With regard to winding down my practice I wanted to get advice on retaining records. I don't know if you (and others) can help here."

A. The best I can do on retention is to quote from the draft revised CR193:

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,[i] 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 six years to bring a negligence claim against an expert and five years to make a complaint to the GMC. As a claim may be brought against the estate of a deceased expert, it is important that appropriate instructions about retention of records are given to experts' executors.

It is on the agenda for when we plan the 2023 Grange conference (along with DPA, GDPR, ICO and subject access issues).

Address

A follow-up to the question: 'I am just starting out doing reports independently and working from home. I was wondering what address do people put on their reports when they use their home as office. Do I have to put an address on my reports or is it enough for the instructing party to have my email address only?'

One of you responded:

'There are as number of Virtual Office providers which for a small monthly fee provide mail handling, telephone answering service and an accommodation address.
I use Regus where their package also includes "lounge access" and five days per month of private office space. This is both professional and cheap.'

I can add that I have occasionally used a Regus office and find it works well. When I was wrongly advised as to the time I was needed at court and needed somewhere to work for a morning in Liverpool I was provided with a space immediately and although I kept reminding them of the time I was due to leave, I left without paying and with the comment that they were pleased to help out!

Commitments list and GDPR

[8] [2020] EWHC 1474 (Fam), 2020 WL 03193151.

One of you responded: 'I believe you are incorrect that sharing your other court commitments and instructing details would transgress "GDPR" as this is a matter of public record once the court order has been issued. However I am not a lawyer but understand some like to gold plate, overinterpret and use GDPR as a reason to say "no".'

I am inclined to agree but as it was a solicitor who reprimanded me, I feel obliged to give heed to what he said.

Handwritten assessment records

Q. I work as an independent expert witness in Care Proceedings employed by the XXXX Trust.

It has been suggested that I ask your advice: my question is regarding hand written notes taken in the course of my interviews, which are a personal aide memoire to the preparation of our typed Court Reports.
As a medical psychotherapist I had considered these to be personal *process notes* as they are selective, highly abbreviated, not particularly legible, and may contain countertransference observations.
However recently my trust has asserted that these are *clinical notes* and are the property of the trust and should be stored by the trust.
I have had advice from the BMA and from the hospital where I work in private practice, that if the definitive document is the typed report then I can and should destroy these notes once they have served their purpose.
As these notes are selective, highly abbreviated, not particularly legible, and contain countertransference observations I am reluctant to hand them over to the trust.

Do you have an opinion on this or any advice?

A. It is clear that you function in two capacities: (1) as an independent expert instructed in care proceedings and (2) as a practising psychiatrist/psychotherapist.

As an independent expert, you should retain your original handwritten records in which you set out the history that you have taken, your examination findings and any other information acquired in the course of the assessment. The reason I say this is because in order for the court to test the reliability of your findings and / or opinion, another expert may be instructed to analyse those records and advise as to the validity of your reported findings and / or the opinion you have given. It does not happen often but experts are sometimes asked to make their records available through their instructing party or to refer to them in the course of their oral testimony. The Criminal Procedure Rules state at r 19(3):

(3) A party who wants to introduce expert evidence otherwise than as admitted fact must—

(a)serve a report by the expert which complies with rule 19.4 (Content of expert's report) on—

(i)the court officer, and

(ii)each other party;

(b)serve the report as soon as practicable, and in any event with any application in support of which that party relies on that evidence;

(c)serve with the report notice of anything of which the party serving it is aware which might reasonably be thought capable of—

(i)undermining the reliability of the expert's opinion, or

(ii)detracting from the credibility or impartiality of the expert; and

(d)if another party so requires, give that party a copy of, or a reasonable opportunity to inspect—

(i)a record of any examination, measurement, test or experiment on which the expert's findings and opinion are based, or that were carried out in the course of reaching those findings and opinion, and

(ii)anything on which any such examination, measurement, test or experiment was carried out.

Experts who are asked to disclose their original records and have not kept copies may find their evidence accorded less weight than it might otherwise be accorded. I was recently involved in a case where an expert refused to make available their records and said that they were affronted by the request. They incurred some criticism from the court and of course it did not help that their reaction revealed their ignorance of the CrimPR relating to expert evidence.

I am not aware of any similar rules in the civil courts or the family court. However, I recall a civil case in which it appeared to me that the 'history' taken from the claimant was nothing more than their responses to the HAD questionnaire, with anxiety and depressive symptoms alternating, in the order in which they appear in the questionnaire and using the questionnaire's severity terminology. The expert was asked to provide their original notes and these comprised little more than the HAD.

There is a provision in the FPR which can probably be used to the same effect:

25.13

(1) Subject to paragraph (2), where a party has access to information which is not reasonably available to another party, the court may direct the party who has access to the information to –
(a) prepare and file a document recording the information; and
(b) serve a copy of that document on the other party.

The expert's handwritten notes probably fall into this category.

So, where you conduct an assessment in order to assist the court with expert evidence, you should retain your original records. Let us suppose that Dr A does and Dr B does not and they disagree as to facts within their expertise or give contrary opinions. If the court can see that the facts described, and / or the opinions given, given by Dr A are consistent with the record of the history and examination, the court is likely to prefer their opinion to that of Dr B or at least to give more weight to the opinion of Dr A than Dr B.

Now turning to ordinary clinical practice, I know of no rule or guidance to the effect that original handwritten records should be retained once the typed record has been created. However, I know that in my Trust, as computerised records were being introduced and clinicians did not have immediate access to a laptop or PC, clinicians uploaded their handwritten records as scanned documents. I would say that good practice is to retain such records. I regard this as defensible documentation. Occasionally in clinical negligence cases I have had the opportunity to compare the content of original handwritten records with what has been recorded on a computer hours or sometimes days later and it is a fact that some loss of detail sometimes occurs, some symptoms do not make it into the computerised record and there is sometimes a failure to record negative

findings. Also in some clinical negligence cases, where clinicians had made the record hours or days later and have not kept their original records, their assertions, in witness statements, that they did ask about x, y and z, are somewhat suspect if this has not been recorded on the computer.

It is true to say that you can destroy the original records that are created in normal clinical practice. However, I would advise against this. I do question the advice that you should destroy them.

Now, perhaps you provide independent expert assistance to the courts as part of your job at the Tavistock. If so, your handwritten notes, even if they are selective, highly abbreviated, not particularly legible, and contain countertransference observations should be retained in the record created for the purpose of the independent assessment. If your Trust is contracting with solicitors or the courts to provide expert reports and to which you contribute, it is understandable that it should require you to retain your handwritten records and file them in the Trust's records system. It is not unusual for experts to be asked to provide a key to abbreviations or to transcribe the illegible. Countertransference is interesting. It reminds me of the last and seldom used part of the mental state examination: reaction to the patient. A powerful countertransference reaction cannot be ignored. You are under a duty to reveal all of the facts on which your opinion is based. If you decide not to rely on it, you need to explain why. You cannot simply not mention it. I am not sure what you mean by the notes being selective. If you have focused on particular aspects of the subject's history or psychopathology you are likely to have used you training and experience to do so. There is no reason to conceal this and indeed the court may be assisted by knowing why you have done so.

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[i] Information Governance Alliance (2016) *Records management code of practice for health and social care*.

October 2022

"I'd rather be a judge than a miner"

When I reflected further on the increased rates of payment to experts in criminal cases and looked at the statutory instrument in full, I was reminded of Peter Cook's sketch in *Beyond The Fringe* and "I'd rather be an expert witness than a barrister" came to mind. As experts we may still complain about the low rates for experts in cases funded by the Legal Aid Agency, but look at how much less a barrister or even a King's Counsel is going to be paid in the same case.

Several of you have asked if these rate increases apply to cases other than criminal cases. They do not. Changes to the rates of remuneration in family and civil cases will have to wait for Parliament to approve a statutory instrument. One of you asked if the new rates apply at the time the quote is sent and not at the time the initial enquiry is sent. My understanding is that they apply to cases for which the LAA grants authority on and after 22 September 2022.

There are some new recipients of this bulletin this month so I attach again the statutory instrument.

Barrister's request to remove material from report

Q. A barrister has asked me to omit information in a criminal report concerning … fitness to plead ... In the substance use history I have included information relating to the defendant's significant alcohol use at the material time and his admission of violence … when he was drinking heavily (understandably he is concerned that it will be prejudicial). I included the information because obviously I am an officer of the court and I can't not include it now I know. I just wanted to check that I am right to refuse to remove the information.

A. An interesting dilemma. You do not say what issues you were asked to address other than fitness to plead and stand trial. If only the latter, it depends on whether or not the facts he admitted, or the fact that he admitted those facts, formed part of your reasoning as to one or more of the *Pritchard* criteria. If your opinion as to fitness to plead and stand trial does not depend on either those facts, or the fact that he admitted them, or if your opinion would be the same even if they did form part of your reasoning (i.e. there is other information which leads to the opinion on the specific *Pritchard* ability) , I think you can remove that information. If however you have relied on it, you must not remove it.

I think that probably your opinion will stand up without relying on this information. Therefore remove the information but refer to doing so in a formal letter in which you indicate that you have removed the information because your opinion does not depend on those facts and make it clear that if accepted as true they are matters which could have implications for trial and / or sentencing issues so your amended report should be used solely in relation to fitness to plead and stand trial. It might be a good idea to amend the section of the declaration where you refer to limitations on the use/disclosure of your report and add: 'This report has been prepared solely in order to address fitness to plead and stand trial and should not be relied upon for any other purpose.'

Parole Board procedure

I am grateful to Paul Egleston who responded as follows to a query in last month's bulletin: "Just to confirm my experience that there is no swearing or affirming at parole board hearings – they are much like first tier tribunals (mental health) where evidence is taken without this process."

NOVEMBER 2022

Bias and expert evidence

A few years ago I wrote a paper with the late Nigel Eastman on bias and expert evidence: Bias in expert witness practice: Sources, routes to expression and how to minimise it. *BJPsych Advances*, 1-11. Doi:10.1192/bja.2021.19.

It prompted a former claimant in a civil case to send me this link:
https://patientcomplaintdhcftdotcom.wordpress.com/

Shortage of experts

Last month I wrote:

A colleague has written: "I am currently flooded with enquiries to take on work, mostly civil cases at reasonable fee rates. I am turning lots down as my waiting list is too long. How do you feel about me putting your name forward to circulate requests among your list of experts? Or can I have names of people who are happy to take on more work. I think experts are in short supply."

As one of you said that they did not want receive requests for reports through my mailing list that limits my use of the group mailing list.

A couple of you did ask to be put in touch with my colleague so that may have assisted to some extent.

So, if you have capacity, I can put you in touch with my colleague.

Criminal procedure in Scotland

You will not find in my book a reference to 'consultations' in criminal cases in Scotland. I now know that what is in England and Wales (and some other jurisdictions) a 'conference with counsel' is a 'consultation' in Scotland. I have also just learned that, having prepared a report for the prosecution, and had a consultation, I can now expect to be called to a consultation with defence counsel. Now that is something that has never happened to me in England except at the start of the trial when the prosecution has advised me that they are not calling me and they then introduce me to defence counsel who will be calling me. There's no property in a witness, as they say.

DECEMBER 2022

Redacted records

A couple of months ago I included in the digest of judgments the Irish case of *Wegner v Murphy* [2022] IEHC 525 and shared it with Damian Mohan who was one of the experts in the case. He has given me permission to share with you his comments on this case.

"Being provided with incomplete or redacted records is a real difficulty here in this jurisdiction. To compound the problem, this case was heard by an inexperienced judge, who has little experience of clinical negligence, as the regular med neg judge was on leave. I include an extract from my report submitted in this case, which, I think outlines my view and reasoning.

- *'To prepare my report, it is imperative to have sight of previous and contemporaneous medical and GP records, including those relating to physical ailments. If adequate records are not obtained, then an exacerbation of a pre-existing disorder may appear to be a new onset disorder. Equally, the examining doctor/expert is obligated to rule out the presence of possible alternative causes of the alleged psychiatric injury. Undertaking a medical examination without having the benefit of previous medical history and clinical notes may result in the false attribution of symptoms to the event under litigation. I would be grateful if you could seek discovery a copy of Ms. Wegner's GP records which predate the alleged clinical negligence by five years, and up to the present time, including any psychiatric reports / outpatient letters (if any) excluding those that are legally privileged as part of these proceedings'*."

Multisource feedack on expert psychiatric witness practice (MAEP)

Are you signed up for MAEP? https://www.rcpsych.ac.uk/improving-care/ccqi/multi-source-feedback/maep

Good wishes,

Keith

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