Annotations

Judicial attitudes to expert evidence in children’s cases

The purpose of this article is firstly to explain the approach of the Family Division1 to expert evidence in children’s cases and secondly to discuss the professional and practical implications of that approach for the expert witness.

Expert evidence is frequently of critical importance in proceedings relating to children, and there are cases in which it is determinative. Given the importance of the outcome of court proceedings for the child, and bearing in mind that judges have no medical training or specialist medical expertise, the dependence of the court on the skill, knowledge, and above all the professional and intellectual integrity of the expert witness cannot be overemphasised.

The ethos of the Children Act 1989 has led since its implementation in October 1991 to a substantial volume of judge made law on the subject of expert evidence. There is not space to examine it all in this article.2 What I hope to achieve is to explain the underlying judicial thinking, and to set out the practical framework within which we expect experts to operate.

Basic propositions

Three propositions underpin the approach of the Family Division to expert evidence. The first is that civil proceedings relating to children are confidential.3 The second is that such proceedings are non-adversarial,4 and the third is that the court has a duty imposed upon it by the Children Act to avoid delay5 and to be proactive in timetabling cases so that they are heard without delay.6

Confidentiality of the proceedings

The fact that the proceedings are confidential means that the court papers in any case can only be shown to an expert with the permission of the court.7 The court thus assumes a proactive role in deciding what expert evidence may be called, the issues to which it should be directed, and by whom experts may be instructed. The advocate who asks for permission to instruct an expert must satisfy the court of the need for expert evidence of the type sought; and since the court is also likely to be timetabling the case when it considers the question of expert evidence, advocates are encouraged both to identify and consult the expert concerned at the earliest possible stage in the case to ensure that he or she will be able to undertake the work within the time scale likely to be allotted by the court.

Non-adversarial nature of the proceedings

The phrase ‘non-adversarial’ is sometimes misunderstood. It does not mean that difficult issues of fact which have to be resolved by rigorous investigation and detailed cross examination do not arise in proceedings relating to children. What it means is that the welfare of the child is the court’s paramount consideration and that the duty of the court is to reach a decision which is in the best interests of the child concerned, as opposed to a result which favours a particular party to the proceedings.8

The fact that the proceedings are non-adversarial is of particular importance for the expert witness because what is known in other branches of the law as ‘litigation privilege’ does not apply in family proceedings.9 In other words, a party who obtains the leave of the court to commission a report from an expert cannot refuse to disclose that report to the other parties and to the court. Thus, whatever the expert’s opinion, it will be read by the judge, even if it is contrary to the interests of the party who commissioned the report.

The importance of the disapplication of litigation privilege cannot be overemphasised. The thinking behind it is, of course, straightforward. As Butler-Sloss L J said in a recent case: ‘when dealing with children, the court needs all the help it can get’.10 If one of the parties has a report from an expert which that party could refuse to disclose, the judge would be deprived of important information.

The consequence for expert witnesses of the disapplication of litigation privilege is that their primary duty to the child and to the court is emphasised. Whatever the source of the instructions, the witness is reporting to the court in order to assist the court to reach a decision which is in the best interests of the child. The primary duty is not owed to the party commissioning the report. Indeed, in cases in which the party who has commissioned the report chooses not to rely upon it, an expert may be called by one of the other parties, or by the court.11 Expert witnesses are thus given the freedom to write wholly objective reports—and are expected by the judges to do so—in the certain knowledge that their opinions will be made known to the judge in any event and, of course, shown to and discussed with their colleagues.

Practical consequences of the non-adversarial approach: assembling expert evidence

A further practical consequence of the non-adversarial approach is that the preparation and presentation of expert evidence in children’s proceedings in the Family Division

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is, or ought to be, a cooperative exercise between the lawyers for the different parties and the doctors. In particular, the experts will not only be encouraged to meet in order to identify areas of agreement and disagreement; it may well be a condition of their appointment that they do so. If logistics prevent face to face meetings, then telephone calls and exchanges of correspondence by fax are encouraged. The whole objective is to define and if possible to limit the issues upon which the court has to adjudicate. In some cases the areas of medical disagreement may prove to be either non-existent or so limited that it becomes unnecessary for any of the experts to attend to give evidence. In other cases, identification of the areas of agreement and disagreement greatly assists the court to focus on the precise issues in the case which it has to determine.

The courts have also laid down guidelines for the way expert witnesses should be instructed. It is, of course, essential that medical experts asked to give reports or opinions in child cases are fully instructed. The letter of instruction should always set out the context in which the expert’s opinion is sought and define carefully the specific questions the expert is being asked to address. Careful thought should be given by the commissioning solicitor to the selection of the papers to be sent to the expert with the letter of instruction, and the letter of instruction should always list the documents that are sent. No doctor wishes to have to spend valuable time reading through papers that are irrelevant to the opinion which he or she is being asked to give. On the other hand, a doctor who ventures an opinion on inadequate material is taking a substantial risk that his or her opinion may be unsound.

Expert witnesses should not hesitate to request further information and ask for additional documentation. Relevant information and documentation should always be made available. Thus, for example, doctors who have had clinical experience of the child or children outside the immediate ambit of the litigation (for example a paediatrician who has examined or treated a child before proceedings (even if only to have their medical notes supplied, which he or she needs time to consider, and which may vitiate the opinion previously expressed in writing.

The expert in court: perceptions and experience
It is very much to be hoped that the procedures set out above assist experts in preparing reports, and also take into account the pressures on their time. However, actually giving evidence in court is still perceived by some as an unpleasant experience due, in large measure, to the belief that cross examination is designed not to examine issues but to mount a personal attack on the expert’s credibility.

In proceedings involving children in the Family Division, I do not believe this to be the case. As I have already said, judges have no expert knowledge on medical issues. It is therefore axiomatic that the doctor will know more about the subject on which he or she is giving evidence than anyone else in court. Of course medical opinions must be sound, balanced, objective, fair, and well researched: and of course if doctors have made mistakes or come to conclusions which cannot be justified by the evidence they must expect their evidence to be rigorously tested; but in my experience as both advocate and judge, experts are treated with courtesy and respect by judges of the Family Division, and I hope that in our courts cross examination which is hostile, discourteous, or personal is simply not permitted.

Footnote
I am conscious that this article is about the guidelines which have been set and about what should be happening. Practice may not always live up to the ideal. But if this is the case, the expert should speak up. Judges want to know if good practice is not being observed. Each circuit in England and Wales has a High Court Family Division liaison judge, one of whose functions is to promote interdisciplinary cooperation on circuit. If an expert has any suggestions to make about the way in which interdisciplinary cooperation can be improved, or any complaint about the way in which he or she has been treated, either by the court or by the legal profession, or if there is a perception that the rules and guidelines set out in this article are not being followed then the obvious person to approach is the Family Division liaison judge for the relevant circuit. Expert evidence in the Family Division is vital for the well being of the children who are the subject of the proceedings: multidisciplinary debate about how we can maximise the quality of that evidence and focus it more clearly on relevant issues is itself also extremely important.

I therefore hope that this article goes some way to reassuring the medical profession that so far as expert evidence is concerned, the judiciary is alert to its importance and is endeavouring to facilitate its use in family proceedings by means of user friendly rules of practice and procedure.

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Majority of meaningful data we have on injuries in children is little about what works in reducing child accidents. The advances in secondary and tertiary care in this area, injury and fear of injury to their children is one of many contributors to anxiety in parents. Injury is costly not only to the NHS, and to the children and families concerned, but which involve risk and danger. Not all accidents or unsafe behaviours result in injury, even if the sequence of events is similar. While in potentially high risk activities such as aviation and anaesthetics, data are collected on avert accidents, and used in the prevention of future disasters, we are less inclined to do this on a systematic basis for child accidents (though every child and parent uses this empirical method themself).

Qualitative research methods in interventions in injury

Not everything that counts can be counted
Injury is the major cause of death in childhood in the UK and other industrialised nations. Moreover injury makes a considerable contribution to short and long term morbidity in children, and fear of injury to their children is one of many contributors to anxiety in parents. Injury is costly both to the NHS, and to the children and families concerned, and while there have been considerable advances in secondary and tertiary care in this area, injury prevention in childhood remains largely unmeasured in terms of its effectiveness. In other words, we know very little about what works in reducing child accidents. The majority of meaningful data we have on injuries in children are based on the sequelae of accidents. What was the injury? What were the consequences? What was the treatment? Data like these, while important, are unlikely to generate the kinds of information we need to prevent accidents.

In order to develop effective interventions for the prevention of injury to children, we need a better understanding of the antecedents of accidents, the environments in which injuries are produced, and the behaviours—of planners, architects, drivers and others, as well as of children and parents—which make accidents more likely.

Some of the work needed to do this will be quantitative, and recent studies in paediatric epidemiology usefully address issues such as exposure to risk, and meaningful denominators. But not everything that counts can be counted. A good deal of data are needed in order to develop and maintain effective interventions in child injury prevention, which can only be collected through careful qualitative investigation.

The preferred medical term in this area is ‘injury’ rather than ‘accident’, however, for the purposes of this note, the term accident is preferred. This is because it is both more meaningful to children and parents, and because it encompasses those events that do not necessarily result in an injury brought to the attention of the medical profession, but which involve risk and danger. Not all accidents or unsafe behaviours result in injury, even if the sequence of events is similar. While in potentially high risk activities such as aviation and anaesthetics, data are collected on avert accidents, and used in the prevention of future disasters, we are less inclined to do this on a systematic basis for child accidents (though every child and parent uses this empirical method themself).

The need for qualitative data in effective injury prevention
The relationship between qualitative and quantitative research is not dichotomous, though it is sometimes presented as such, with qualitative data characterised as ‘soft’; quantitative data as ‘hard’; qualitative data as anecdotal; and quantitative data as ‘scientific’. An over-reverent approach to quantitative data supports the empiricist fallacy that figures are simply given objective facts, a proper understanding of which leads to one ‘correct’ conclusion and one conclusion only. The suggestion that quantitative methods are reliable but not valid, while qualitative methods are valid but not reliable overstates the case, but the lack of ‘fit’ between the prevention messages and the realities of keeping children safe underlies the need for an approach that combines the best of qualitative with sound quantitative methods. Without an understanding of the lives and lay expertise of those on the receiving end of our well meaning efforts, we risk ineffective, or worse, intrusive and harmful interventions, which may, for instance, raise the level of anxiety about risk while doing nothing to reduce the risk itself. A recently