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What price justice? Experts or treating clinicians? *LB Islington v Al Alas and Wray*

JO DELAHUNTY QC, 4 Paper Buildings
KATE PURKISS, Coram Chambers

In June [2012] Fam Law 659 we, who acted for the mother in *LB Islington v Al Alas and Wray* [2012] EWHC 865 (Fam), [2012] 2 FLR (forthcoming) provided an analysis of that important case and highlighted some of the issues arising from the judgment of Theis J and the evidence that had informed it in the preceding 6 week trial. In cases like *Al Alas* there is a small pool of available experts. The science on which their opinions depend is complex and sometimes controversial. The acceptance or rejection of those opinions by the court has a pivotal effect on the outcome for the family at the heart of the case. This second article considers a number of issues about the proper reliance on experts and the effective use of them in such cases. There is no arena in which the role of experts is more keenly debated than in cases involving baby shaking and the triad of injuries relied upon to prove it, classically identified as consisting of retinal haemorrhages, subdural bleeding and encephalopathy. The relative freedom of our colleagues at the criminal bar to select, fund and liaise with the experts they deploy in the criminal jurisdiction is to be contrasted and compared to the protocols and funding restrictions which guide the family justice system and those who practice within it in this critical field. This distinction may become all the more stark if government plans are implemented which propose that care proceedings should be concluded in 6 months from issue and restrictions on the use of experts are contemplated in order to make that an achievable timescale. We pose the question whether swift justice may lead to injustice, particularly given the

restrictions imposed on expert funding, instruction and liaison.

The debate

The feverish debate about the use of experts in care proceedings conducted in the media reflects the conflicted stance society takes on the emotive issue of child protection when a particular story breaks in the national media. Yes it can be a gross injustice to child and parent alike for social workers, backed by 'expert' opinion to wrongly remove children from their families but it is equally unacceptable for vulnerable children to be left at home to suffer abuse at the hands of those who should protect them. Take your pick as to which angle makes headline news in relation to the story of the day.

Society needs a rational debate about how to balance the rights of a child, when there is a conflict between a child's right to grow up in its family of origin and at the same time offer protection against parental abuse or neglect within that family. For the time being, the criminal justice system offers a remedy *ex post facto* and the family justice system attempts intervention at an earlier stage before such abuse has occurred, if not to protect the child who has already been harmed or killed, then at least to protect any vulnerable siblings who might also be at risk.

The context

The debate on this issue needs to acknowledge the crippling financial constraints under which the family justice system operates. Practitioners in this field

are all too familiar with the daily complaints of local authorities that there are insufficient funds to ensure that the cases requiring their statutory intervention are adequately managed. The family justice system, whilst requiring as a matter of law, the separate representation of children in specified proceedings, has had to operate for years with variable delays in the appointment of Cafcass guardians and restrictions of what they are able to do in the exercise of their role once allocated. The courts are inundated with ever more applications and try to determine them as quickly as possible, yet work within finite restrictions imposed by availability of court rooms, judges and staff. Those practitioners who still represent the publicly funded parties in care proceedings face lengthy daily bureaucratic battles with the LSC for funding approval each step of the way before they have even been able to think about case strategy. The potential for each or any of the above pressures to impact upon the welfare of a child should be self evident. The case of *Al Alas* highlights a number of specific areas of concern.

Adversarial experts: the elephant in the room

There are few cases which inspire stronger views from not only the public at large but from the professionals who work within the family justice system than cases concerning injuries alleged to have been inflicted and which demonstrate the triad (encephalopathy, retinal haemorrhages and subdural haematoma). As Theis J observed at para [221]:

‘This is an area of some controversy with strong feelings on both sides of the medical profession.’

It is a complex area of medicine particularly in relation to the causation of subdural haematoma and whether or not hypoxia is a possible cause. There continues to be genuine disagreement amongst eminent experts often stridently expressed. There is a real danger for children and families that cases in which experts are called to offer opinion evidence in relation to the triad play out their own particular views, using scientific research selectively to reinforce their opinion in relation to fact and child specific situations.

As Professor Nussey observed in *Al Alas* ‘some of the papers were being used a bit like academic grenades and thrown into the argument to justify points rather than informing the discussion. He said it is very difficult to make generalisations when you are dealing with something at one end of the spectrum.’ (para [156])

Experts are required to cite research to support their own theories and to alert the court of that science which might contradict their view: but is a case about a particular child an appropriate forum for any detailed and considered arbitration on the science? Do we, whether advocates or judge, have sufficient scientific and medical expertise to trawl through the research, unpick its applicability to the case in hand, and apply and deploy it in cross examination or analysis of the experts that are called up before us? As the legal profession struggles to keep up with the evolving science in relation to the triad, the court in care proceedings is enjoined to, ‘never forget that today’s medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark’ (*R v Cannings* [2004] EWCA Crim 1, [2004] 1 WLR 2607).

We ask whether the time has come for the courts to acknowledge that if justice is to be done in these cases, we can no longer keep our experts at arms length. By so doing, do we risk injustice in particular cases and elevate decisions on the science in specific cases to an importance which may not be justified in the context of the wider medical debate? The exploration of the science within any particular case involving the triad will be informed by a number of factors:

- (a) the expert’s selection and use of research materials in support of and contrary to their opinion evidence;
- (b) the advocates’ awareness and understanding of the research, which may need to go beyond that identified by the expert;
- (c) the ability of the advocate to understand the science to apply it to the clinical picture so as to cross examine the expert in ‘real-witness-box-time’ relying only on the advocate’s knowledge and wits challenging the expert in his own field

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of specialism there is no opportunity to 'phone a friend' or turn in court, as our criminal colleagues can, to ask the expert sitting behind them to decode the complex evidence being given so as to compose a rebuttal or pursue a forensic challenge.

This is far from ideal. Isn't it simply unrealistic to expect advocates who are not medics and who operate under increasingly threatened remunerated preparation to advance a forensic case with an appropriate degree of knowledge to inform an inquisitorial process in such a complex area of science? Don't risk creating a lottery for those lucky clients who can be represented by advocates 'in the know' on the science and those who unfortunately are not? Has the time come to acknowledge that the inquisitorial imperative within our family justice system depends in large measure on the respective abilities of the advocates lined up on either side of the case? Whilst care proceedings are not adversarial proceedings, that's not how it feels to the parents of children who are threatened

with permanent removal, nor is that how it is perceived by society at large.

There is an additional aspect to this concern. Many experts now actively consider whether they are prepared to submit reports in family proceedings. They can feel unsupported within the family court by contrast to their experience of giving expert evidence in other litigation. From the expert's perspective, he/she has to rely on the skill and understanding of the advocate to draw out the relevant medical points for judicial consideration without being able to contribute to the advocates' understanding of the evidence. In a process in which their professional reputations may be at stake, this is unfair and threatens to reduce the pool of available experts further.

We advocate enabling the advocates in family proceedings to liaise with their experts in the same way that is open to advocates in other civil litigation. Why should experts, whose evidence in this area is the most dense and difficult to understand, fall into a different category than any other witness? Greater

understanding amongst legal practitioners of the subtleties of the debate can surely only increase confidence in the outcome of cases.

The choice of expert: family proceedings: the poor relation?

Expert reports are expensive disbursements. Of course, there is good reason given the constraints on the public purse, why the family courts should scrutinise carefully a party's proposal to obtain and rely upon expert evidence. The Family Justice Modernisation Programme aims to:

'... further reduce the need for expert evidence in both standard and exceptional tracks, we will enlist the help of the Family Justice Council and join with Government in the publication of peer reviewed research as to evidence-based good practice. Not only will pathway documents be available giving guidance as to the form and content of materials for use in court but judges will have available to them research materials which are uncontradicted i.e. generally accepted by a reasonable body of professionals. That would not of course prevent a dispute being heard relating to such materials but it will concentrate minds as to the need for the same in many cases.' (Ryder J, Fourth Update Family Modernisation Programme)

While it is clear from the updates provided by Mr Justice Ryder in relation to these proposals that the real focus is a case where threshold is agreed at the first contested interim hearing and the outstanding issue for determination is therefore welfare outcome and not adversarial fact finding as in *Al Alas*, that restrictive approach is inconsistent with the statement in the update that such an approach can be taken where the threshold is plain (obvious but not established?) at that hearing because interim threshold upon which an interim care order relies must in its reasoning have identified prima facie evidence in support (Fourth Update, March 2012). The Care Monitoring System Guidance for Practitioners suggests that a form of order in relation to the decision on the instruction of an expert will include the reason for

permission being granted such as the absence of expert evidence from local authority/Cafcass or an identified necessity on a relevant issue outside the skill and expertise otherwise available to the court.

We are very concerned that a change in culture which restricts the use of expert evidence where the local authority (LA) already has such evidence, and where the interim threshold has been established, may be interpreted literally by the lower courts in cases involving disputes on both threshold and welfare. In reality this will impact mainly on respondent parents in contested care proceedings. While the burden of proof is on a LA in care proceedings, where it adduces such evidence at an early stage, why should a respondent be denied the opportunity to call expert evidence to challenge that opinion? In a case such as *Al Alas*, such restriction would have resulted in catastrophic injustice.

Moreover, most practitioners will agree that even where the court authorises expert evidence on the application of a respondent party to care proceedings, it does not necessarily follow that the Legal Services Commission (LSC) will permit funding for the expert even where the argument is won in principle; there will probably still have to be a haggle over the hourly rate. The practical effect of this for publicly funded respondent parties is that there is in reality a two-staged hurdle to expert evidence.

The better experts are busy not only with their clinical and research commitments but are much sought after for their opinion evidence. Consequently, as a general rule, they tend to be more expensive, which may rule them out of giving evidence in family proceedings altogether. Even if the funding issue doesn't exclude them, they will probably take longer to report. It can be hard to circumvent a time-based objection to a particular expert in a system which operates under the general principle of s 1(2) of the Children Act 1989 that any delay in determining the question is likely to prejudice the welfare of the child. For all of these reasons, it is increasingly hard to find reputable experts who satisfy all of the criteria. With a 6 month time scale under contemplation a crisis potentially looms large on the horizon.

Treating medics: expert enough?

In cases like *Al Alas* where a LA, which has not been involved in a child's life because of historic concerns about parenting, is propelled into urgent action by allegations of inflicted injury and death, it is perhaps inevitable that the evidence which gives rise to that allegation will emanate, at least in part, from those medical professionals who treated the child. They form opinions in less than ideal circumstances because timely medical analysis and intervention is the clinical imperative. The hospital work place is not immune from suspicion and corridor discussion where opinions are formed as evidence is emerging and emotions run high. Treating medical professionals in such situations will have formed a clear view or opinion and if their evidence is put before a court by a LA it is because they have decided that injuries have been inflicted.

Experts instructed within family proceedings have an overriding duty to the court that takes precedence over any obligation to the person from whom the expert has received instructions or by whom the expert is paid (Practice Direction 25A, para 3.1). Historically the practice has been not to commission expert reports from treating clinicians. In the case of *Re B (Sexual Abuse: Expert's Report)* [2000] EWCA Civ 516, Thorpe LJ said:

'It ought to be elementary for any professional working in the family justice system that the role of the expert to treat is not to be muddled with the role of the expert to report.'

However, there is no embargo on such evidence being obtained if appropriate. As Thorpe LJ observed in *O-M, GM (and KM) v The Local Authority, LO and EM* [2009] EWCA Civ 1405, [2010] 2 FLR 58:

'[C]linical involvement did not, of itself, affect a doctor's capacity to act as an expert witness; a blanket approach that precluded treating clinicians from becoming jointly instructed witnesses in respect of children they had treated would risk depriving the court of expertise and excellence.'

But he drew a clear distinction in respect of experts who had firm views as a result of

their treatment of the child about the very issue the court had to determine:

'Medical evidence was to be looked at in terms of the court proceedings: there was a clear distinction to be drawn between a medical decision as to what was clinically required for a child's treatment and a forensic decision about what was necessary to ensure a proper determination of an issue.'

We are worried that at the very time when the family justice system is struggling to meet the twin objectives of curtailing expenditure and delay and where the medical professionals involved in a child's treatment have the authority not only of their professional standing but of having given opinion evidence to the family courts in other cases, it may be difficult to resist the suggestion that the court should afford them the status of experts.

However, the case of *Al Alas* highlights the very real difficulty in relation to such a proposition. The court's enquiry into causation of injuries and death was in effect a consideration of whether or not the opinion clinicians formed when treating Jayden was valid. This was relevant to the adequacy of the treatment, which was in turn relevant to the issue of causation of encephalopathy. The court had the benefit of all of the evidence and could take an unfettered view in relation to the treatment given. In *Al Alas*, this enquiry included not only detailed forensic examination of Jayden's treatment in life at both University College London Hospital (UCLH) and Great Ormond Street Hospital (GOSH) but his parents' evidence, the evidence of other witnesses, the chronology of his deterioration leading up to his admission to UCLH and then after admission to UCLH; CCTV of Jayden and his parents en route to and at UCLH, which demonstrated to the surprise of treating clinicians at GOSH that he had been conscious on arrival at UCLH. As Mrs Justice Theis observed:

'I am very aware that this court has had the opportunity, as did the CCC, to consider the events of the 22.7.09 – 25.7.09 in exhaustive detail, with the benefit of expert evidence over a number of weeks. I am acutely aware that the clinicians operating on the ground, dealing with such urgent

situations as occurred in this case, simply don't have that luxury.'

In *Al Alas* eminent treating clinicians at GOSH had formed a clear and forcefully expressed opinion that Jayden's injuries were inflicted. They were wrong. Following the acquittal of the parents at criminal trial GOSH was subjected to adverse criticism in the media. As the Court of Appeal urged in *R v Cannings* (above), courts should approach the evaluation of medical expert evidence and always be on guard against the over-dogmatic expert, the expert whose reputation or amour propre is at stake, or the expert who has developed a scientific prejudice.

The case of *Al Alas* was described by the experts as extremely complex (para [6]). Mrs Justice Theis recorded that the complexity of the case is perhaps obvious by the length of this judgment and the breadth of expert evidence the court has heard from (para [234]). The case undoubtedly required the full range of expertise of the different professionals called to provide opinions. The family team for Chana Al Alas was very fortunate in being able to rely within the family proceedings upon expert evidence which had been obtained already by her criminal defence team for use in the murder trial, notably a number of eminent overseas experts whose contribution to the case was crucial in its outcome. Before obtaining permission to instruct an overseas medical expert in family proceedings, a party needs to satisfy the court that the expert has something genuinely exceptional to offer in terms of his/her expertise and must also explain in writing: (1) why a UK-based expert is not to be used; and (2) what efforts have been made to identify a suitable UK expert. (See the Experts Committee of the Family Justice Council Guidelines for the Instruction of Medical Experts from overseas in Family Cases, December 2011). While the court might look more favourably now upon such an application in respect of the overseas experts who gave evidence in *Al Alas*, but for the instructions already made within the criminal case, we very much doubt, even in the context of a case of this extreme complexity, that we would have been able to secure court permission for or LSC approval of the funding for all of the

experts assembled in this case (notably the overseas experts) within a time frame which is likely to have been acceptable to the family court. We were lucky: they were already 'on board' and had provided their opinions.

Had this case required conclusion within 6 months, there would have been no realistic prospect of obtaining the expert evidence which exonerated the parents in the family proceedings. Following their acquittal at the criminal trial, it is likely that the parents would have had to apply to re-open any findings made. Potentially this would have created additional delay and expense. More importantly, it would have resulted in a very real injustice.

Moreover, within the criminal trial counsel for the parents were able to make full use of the expert knowledge of those they had instructed. They were able not just to read their written reports and submitted research but to talk to them and ask them questions before court, in court and after court. That access to excellence led to a real testing of the evidence that helped secure the acquittal of the parents.

By contrast in our care case, lead and junior counsel took up where the criminal case had left off. We led the cross examination and challenge to the science and the clinical picture that needed to be compared and applied to it and in so doing worked from the criminal experts' reports, their research, and their transcripts of oral evidence at the criminal trial. We were lucky as we had an excellent foundation prepared for us. We were also fortunate in having a judge in Theis J who was knowledgeable about the science and open to its exploration. However, what we could not do when we started to unravel and explore the areas of concern arising from both the clinical mis/management of Jayden at UCLH and the ramifications of GOSH's failure to detect radiological evident signs of rickets, was to decode the x-rays or ask questions of the medics with a full understanding of the complex picture that was unfolding, de novo, in the witness box. What was the relevance of fluctuating CO2 levels or the lactate level? What was the significance of pulsometer readings of 100% saturation levels and how did this militate against a diagnosis of hypoxia? Had there been a deliberate policy of hypocapnia? In fact what was hypocapnia?

Dr Peters (Consultant Paediatric Intensivist) had been 'upgraded' by the LA to the role and status as an expert in the care proceedings. He had been asked to provide a report in the criminal trial on the child's treatment at UCLH as well as his own hospital (GOSH). He had given evidence at the criminal trial, filed various s 9 statements and reports and proffered another to the care case. In none of them had he sought to explain Jayden's clinical management at UCLH in the way he did, for the first time in the witness box in the care case.

We operate on the basis that what needs to be known of an expert's opinion is written down, disclosed in time to be considered so that there is transparency of the opinion and analysis of the research and facts that inform it before the witness gives evidence (FPR 2010, r 25). It is that 'advance notice' and transparency which is meant to allow the advocates to challenge their evidence in the witness box. When a witness who is giving opinion evidence goes 'off piste' (as did Dr Peters) the consequences for the parties can be profound. An advocate cannot simply rely upon a thorough knowledge of the facts or an understanding of the opinions already provided to rebut an 'expert' analysis of the clinical picture when the interpretation is subjective and open to differing conclusions (as later became apparent). We were compelled to apply for, and we obtained, an adjournment of his evidence, reserving our cross examination of Dr Peters in order to disclose a live note transcript of his evidence to our experts and to receive their response to it. Professor Nussey was interposed and gave his analysis of Dr Peters' evidence and the medical records in chief. Dr Peters was then recalled and Professor Nussey's evidence put to him in cross examination. A 6 week time estimate and a fair minded judge accommodated this process. This combination, plus the clarity of a live note of Dr Peters and Prof Nussey's evidence so that its complexity was not 'lost in translation', prevented a potential injustice to this young mother. When science is this complex and the debate much fuller in the Family Division than that in the criminal trial where, ultimately it has to be understood by the jury, we enter difficult and dangerous territory. The outcome may depend on a

number of variable factors: the competence and courage of the advocate to take a stance that is unlikely to be welcomed by fellow counsel and the court; the particular attitude of the judge and the availability of the experts to do more than expected of them in terms of analysis; not forgetting, of course, the ever present bureaucratic hurdle to be overcome of prior approval for additions to the case plan by the LSC, which need to be obtained by the solicitor at break neck speed if such a situation arises. We believe that *Al Alas* provided clear examples of the dangers of relying on the treating medics: Dr Hiorns as radiologist and Dr Peters as Paediatric Intensivist were key examples in this case. We believe that had their opinions been relied upon the outcome for this young and blameless family would have been very different.

With the 6 month guillotine of family proceedings now a real possibility in family courts, parents face a two track time line when criminal proceedings are also underway with very different potential outcomes. In the family court, with more limited access to expert evidence, an outcome and conclusion within 6 months (given we do not yet know how the 'escape' clause will be interpreted or the regularity with which it will be exercised). That conclusion may lead to a placement order with life long and consequences for the parent and child. Time for appeal is limited. The consequences of the orders are played out: care plans are implemented. In the meantime, in the criminal trial, a longer timescale allowing for the instruction of a wider pool of experts leads to an acquittal as a result of expert evidence where the 'opinions' of treating medics are called into question and 'trumped'. What then is a parent to do? Apply to set aside the family findings? If the child hasn't been placed, that leads to uncertainty and delay as a minimum. If not allowed, it leads to potential injustice for the family. If the child has already been placed for adoption, the prospects of being able to turn back time are remote (as in the case of *Webster v Norfolk County Council and the Children (By their Children's Guardian)* [2009] EWCA Civ 59, [2009] 1 FLR 1378, an appeal against existing adoption orders and earlier care

orders on the basis that the original care order was a miscarriage of justice, ie scurvy not NAI).

As we said at the outset of this article, swift justice may lead to injustice if the court does not have before it the evidence that is pivotal to its final decision. We must protect our right to use experts. We must explore ways in which we can make greater use of their expertise, while still maintaining the transparency upon which

the family justice trial system depends. What we cannot do, we believe, is to allow the proper forensic use of experts to be restricted by artificial time constraints and cost limitations which mean that the family justice system may be on a fast track to potential injustice.

The authors acted for the first respondent mother, Chana Al Alas.