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Responsibilities of psychiatrists who provide expert evidence to courts and tribunals

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on behalf of the Special Committee for Professional Practice and Ethics

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COLLEGE REPORT

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In memoriam of Professor Nigel Eastman.

The role of the College in expert evidence

The College believes it is crucial that courts can draw upon qualified and expert testimony in support of informing its decisions and conclusions in individual cases. This report provides support to psychiatrists in assessing whether they have the competencies required to undertake the role of an expert witness and – where they do believe they can do it – what principles and issues they might need to consider in doing so.

However, the College does not provide endorsement for, or make a judgement on, any evidence given or on individual cases. The responsibility for that rests entirely with the psychiatrist concerned and the legal jurisdiction where it is being provided.

Executive summary

The administration of justice depends on the willingness of psychiatrists to play their part by offering expert assistance as and when required. The guidance in this report is intended to ensure that psychiatrists who provide expert evidence to courts and tribunals adhere to the highest professional and ethical standards in fulfilling this important public function.

Psychiatric experts may be required to assist within a wide variety of medicolegal matters, in a variety of legal contexts.

Law and practice are constantly evolving, so that it is important to read this guidance alongside information on developments in statute and case law and, where appropriate, to seek and to take into account formal legal advice as to the significance of such developments.

The expert witness must comply with a number of duties, some common to all expert witnesses and some specific to certain courts and jurisdictions. Expert witnesses who provide training and supervision have additional duties, as do those they train or supervise.

Expert testimony, or expert evidence, is information which is relevant, likely to be outside of the experience of a judge or jury, based on a reliable body of knowledge or experience or for which there is a sufficiently reliable scientific basis for the evidence to be admitted.

The decision as to whether or not a psychiatrist has the appropriate or relevant expertise for a particular case is initially made by the parties, but ultimately by the court or tribunal. However, in making this ultimate decision, the court or tribunal has to be able to rely upon information provided by the expert.

There is a duty for psychiatrists who give expert testimony to ensure that such work is included in their appraisal for revalidation.

Apart from under exceptional circumstances, psychiatrists who provide expert evidence should hold a licence to practise. This even applies in cases where there is no clinical contact in the form of history-taking and examination.

Specialist forensic psychiatry trainees are required, as a core part of their training, to acquire knowledge and skills concerning law and the interface of law and psychiatry.

Psychiatrists have a duty not to give evidence or opinion on matters outside their areas or fields of expertise

It is the duty of any psychiatrist to assist the court to ‘effect’ justice and never to seek to ‘affect’ it. This means being able to reflect upon how their own values and other sources of bias might influence the opinions they give.

Psychiatrists will likely need to decline instructions in cases where they have competing or conflicting interests.

Where people involved in legal actions are adversely affected by experts who cause delays, those experts may be at risk of financial penalties, such as a wasted costs order.

It is generally inadvisable for the treating clinician to provide expert testimony within litigation involving their patient, although there are exceptions.

The first, or overriding, duty of the expert is to the court and to the administration of justice; but psychiatrists should not ignore their ordinary clinical ethical duties as doctors when evaluating individuals for the courts.

Psychiatrists may occasionally be asked to prepare reports without consulting with, or otherwise directly assessing, the subject of the report; but such a report should not usually be prepared without either the consent of the subject of the report or the agreement of the parties to the litigation or an order from the court.

In some circumstances, a psychiatrist may be asked not to provide a report for the court, but to offer a critique of, or commentary upon, the report of another expert, in the role of 'expert advisor'. This should not be confused with providing an independent opinion to the court.

Similarly, a psychiatrist in a criminal case may be provided with a defence psychiatric report and asked to comment upon it in order to inform a charging decision or to assist as to a defence that is raised; and, again, this should not be confused with providing an independent opinion to the court.

In order to base an opinion as to diagnosis on subjective symptoms, the expert has to assess the worth of the evidence overall. Multiple primary sources of information, independent of the individual assessed, are essential.

It is for the court to determine the ultimate issue of culpability and subsequent need for punishment, not the expert, although the expert may offer expert advice on causal relevance of the defendant's mental disorder in determining commission of the index offence.

It is ethically problematic for experts to explicitly recommend a section 45A hybrid order, because this amounts to recommending punishment. This is distinct from giving expert evidence concerning the therapeutic or public safety implications of such an order, compared with imposition of a s37 hospital order.

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.

Psychiatrists giving evidence in the family courts need to be able to show that they have the particular, necessary training and expertise in this complex field.

An expert who uses a published psychometric test, instrument or tool, such as a risk assessment, should be prepared to be cross-examined on its validity and reliability, particularly in relation to medicolegal settings, by a cross-examiner who is assisted by an expert who is qualified to administer the test, instrument or tool and/or is familiar with the literature relating to it.

Experts should strive to respect the normal duties of confidentiality, which should include proper procedures for the secure storage of documents and records such as the use of passwords and/or encryption, to ensure the security of electronic files.

Other than exceptionally, such as where there is an overriding public interest in disclosure, reports should not be disclosed without the subject's consent and/or consent of their legal representatives, or unless directed by a court.

Experts need access to a complaints procedure, and every effort should be made to resolve complaints before the General Medical Council (GMC) becomes involved.

A complaint made when a case is ongoing, particularly if it is accompanied by a threat of referral of the expert to the GMC, immediately runs the risk of being perceived as amounting to pressure being placed upon the expert and must result in the expert having to withdraw from the case.

Any action taken against another expert should be conciliatory, constructive and respectful.

Experts who engage with, or come across, erring experts in litigation are probably best able to expose and delineate their shortcomings and misdemeanours and they do a disservice to the profession if they turn a blind eye and do nothing.

The very few cases of psychiatrists whose 'fitness to practise' has been found to be impaired by the GMC or, now, the Medical Practitioners Tribunal Service (MPTS), as a result of their practice as an expert witness, helpfully give an indication of the nature and degree of the failings which may be judged to amount to such unfitness.

Psychiatrists concerned about potentially having a negative effect on litigants may choose to withdraw from particular classes of expert witness work. However, this may leave the courts increasingly reliant on a pool of experts who appear to favour less therapeutic approaches, thus distorting the range of expert opinion available to the court.

When courts require assistance in novel areas, it is better for them to be assisted by provisional or qualified, or even heavily qualified, opinions and to understand the limitations, inadequacies and weaknesses of research and guidance than to have no assistance at all.

Introduction

Courts require expert testimony on a huge number of issues that entail specialist knowledge. The vast majority of expert testimony in the courts is non-medical, and only a small proportion of medical expert testimony is psychiatric.

Psychiatric experts may be required to assist within a wide variety of medicolegal matters, in a variety of legal contexts. For example, in regard to:

- the state of mind of defendants in criminal cases, in relation to a variety of legal issues or tests
- the sentencing of offenders (usually in the context of mental disorder)
- the assessment of complainants and witnesses with regard to such matters as vulnerability and reliability
- psychiatric injuries that are at issue in personal injury litigation in the civil courts
- allegations of negligent psychiatric care
- the mental health of parents and children in family cases, including offering advice on safeguarding of children and young people and advice to parties in secure accommodation proceedings
- the risk of physical or emotional harm posed by parents with mental health problems to their children
- the effect of mental disorder on fitness to work and in relation to ill-health retirement
- professional regulation where the mental health of professionals, or the professional conduct or performance of psychiatrists, is under investigation
- the mental capacity of people making various types of decision.

This list is far from exhaustive.

In the family courts there are particular concerns about both the shortage of psychiatrists willing to assist with expert evidence and what is perceived by family lawyers as a decline in the quality of reports by child, child and family and adult psychiatrists (Family Justice Council, 2020).

There is a considerable body of guidance available to experts in general, including doctors and psychiatrists. This includes the GMC's Good Medical Practice and Acting as a Witness in Legal Proceedings and the Academy of Medical Royal College's Acting as an Expert or Professional Witness: Guidance for Healthcare Professionals.

Furthermore, all those who act as experts may be required to comply with certain procedural rules and 'practice directions'. These rules and practice directions for experts vary by court or 'jurisdiction' and are constantly evolving.

In England and Wales, the rules and practice directions with which psychiatrists are likely to need to be familiar are the Civil Procedure Rules Part 35 and its practice direction, the Criminal Procedure Rules Part 19 and its practice directions, and the Family Procedures Rules Part 25 and its practice directions.

In addition, experts in civil claims must have regard to the Civil Justice Council's Guidance for the instruction of experts in civil claims published in August 2014. Further, although the government has not acted on the recommendation of the Law Commission (2009) that Parliament should publish a bill dealing with the admissibility of expert evidence, the Law Commission's recommendations have been embodied in the Criminal Procedure Rules since 2014 and, albeit they are not binding outside the criminal jurisdiction, they are likely to influence the approach to, and use of, expert evidence in civil and other legal jurisdictions.

England and Wales have the most, and the most highly developed, rules and directions in the British Isles and they may be influential in other jurisdictions.

Guernsey, for example, does not have much in the way of rules and has no equivalent of the Criminal Procedure Rules. However, in dealing with procedural matters, if it is considered helpful, the court looks at what happens in the Crown Court in England and Wales. The Isle of Man has no rules analogous to the Criminal Procedure Rules, but experts are encouraged to follow best practice in England and Wales or other jurisdictions.

In civil litigation, the Channel Isles have the Evidence in Civil Proceedings (Guernsey and Alderney) Rules 2011. The Isle of Man has the Rules of the High Court 2009, as amended, which mirror the Civil Procedure Rules. Northern Ireland relies on the Rules of the Court of Judicature (Northern Ireland) 1980 which are similar to the rules in England and Wales which preceded the Civil Procedure Rules.

In family cases, Northern Ireland has the Family Proceedings Rules (Northern Ireland) 1996 but also relies on the Rules of the Court of Judicature and Ireland has the High Court Practice Direction in Family Law Proceedings.

Finally, it is important to bear in mind that law and practice are constantly evolving. By the time this guidance has been published there are likely to have been further developments that may render some of it out of date. It is therefore important to read this guidance alongside information on developments in statute and case law and, where appropriate, to seek formal legal advice as to the significance of such developments.

The expert's duties

The expert's duties to the court include:

- assist the process of justice
- act impartially, objectively, and honestly
- reveal any actual or potential conflict of interest
- make clear the limits of their knowledge or competence
- give testimony only in their area or field of expertise
- state the substance of all facts and instructions given to them which are material to the opinions expressed in their report or on which their opinions are based
- indicate the sources of factual information, including indicating where they have no personal knowledge
- not to usurp the role of the fact finder by opining on the ultimate issue or finding disputed facts unless directed to do so or unless doing so requires expertise
- mention all matters that they regard as relevant to the opinions they have expressed
- consider any relevant material which may be available in the field of psychiatry and not to draw conclusions merely based on their own experience
- be accurate and complete
- draw to the attention of the court all matters that might adversely affect their opinion
- not to include in their evidence anything that has been suggested to them by anyone, including the lawyers instructing them, without forming their own independent view of the matter
- provide the court with evidence about the range of opinion, or reasonable opinion, on the material issue(s) and to provide reasons why the expert believes that their own position within the range represents the preferred opinion; this will include not only referring to evidence that goes against their opinion, but also explaining why that contrary evidence is not sufficient to invalidate their opinion; where there is no available source for the range of opinion, the expert has to make clear that the range that they summarise is based on their own judgement, and also explain the basis of that judgement.
- in any discussion with an expert or experts from the adverse party, not to reach agreement on points of disagreement for the convenience of the court
- support opinion with sufficiently thorough reasoning for the court to assess the validity of the opinion
- where relying on the views of others, to record from whom those views were obtained
- where constructive input has been provided under a peer review arrangement, or by way of supervision, a duty to reveal this and to identify the peer or supervisor
- make it clear if their opinion is in any way qualified or provisional
- promptly communicate any change of opinion, and the reasons for such change
- not to enter into any arrangement where the amount or payment of their fees is in any way dependent upon the opinion they have given or the outcome of the case
- have in place appropriate professional indemnity insurance for medicolegal work

The Criminal Procedure Rules (Ministry of Justice, 2022) impose additional duties on expert witnesses in the criminal jurisdiction in England and Wales to:

- disclose any information capable of substantially detracting from their credibility or impartiality
- define their area, or areas of expertise
- include in their report such information as the court may need in order to decide whether their opinion is sufficiently reliable to be admissible

The Crown Prosecution Service (2022) notes that the accompanying Practice Direction (Criminal Practice Direction V) includes as an example of information capable of substantially detracting from the expert's credibility: "any adverse finding, disciplinary proceedings or other criticism by a professional, regulatory or registration body or authority, including the Forensic Science Regulator".

As the reference to 'disciplinary proceedings' is sandwiched between "any *adverse* finding" and "*other* criticism" [our emphasis], this implies that this duty does not encompass: (i) disciplinary proceedings which have not concluded with an adverse finding or criticism or (ii) disciplinary proceedings which have not been concluded as they might not reasonably be thought capable of substantially detracting from the expert's credibility.

The duty to be accurate and complete is often interpreted as meaning that the expert cannot omit anything from their report which is material to their opinion. The GMC states: "You must not deliberately leave out relevant information". However, at least in criminal cases where, in the expert's professional judgment, their report includes information which it would not be in the public interest to reveal to another party, CrimPR r 19.9 provides that such information can be omitted in order for the court to decide if it should be disclosed to another party or parties. This issue might arise if the disclosure of the information could result in a real risk of serious harm or death to a third party. Although there is no similar rule in other jurisdictions, this is a procedure which could be followed in other circumstances by way of a request by the expert to the court for directions.

An expert who acts as a trainer has a duty to keep the trainee's competence under frequent review; so that at every stage they are satisfied that what is expected of the trainee is consistent with their level of experience and current competence and matches the complexity of the case.

There is a complementary duty on the trainee to be clear with their trainer about the extent of their knowledge and experience and their duty not to act outside their area of expertise.

The legal nature of expert testimony

[This section is based on Rix K, 'Expert evidence: Frequently asked questions' (2021) Journal of Forensic and Legal Medicine with the permission of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians.]

What is expert evidence?

Expert testimony or expert evidence is 'information which is likely to be outside of the experience of a judge or jury' because '(if), on the proven facts, a judge or jury can form their own conclusions without help, then the opinion of an expert is unnecessary' (*R v Turner* [1975] QB 834). It is information that belongs to 'a reliable body of knowledge or experience' (*Kennedy v Cordia (Services*) LLP [2016] UKSC 6) or for which there is a sufficiently reliable scientific basis for the evidence to be admitted (Criminal Practice Direction V Evidence 19A.4).

Hodgkinson and James (2015) in *Expert Evidence: Law & Practice*, tentatively distinguish five categories of expert evidence, with the realisation that their classification may not be exhaustive:

i. expert evidence of opinion, upon facts adduced before the court
ii. expert evidence to explain technical subjects or the meaning of technical words
iii. evidence of fact, given by an expert, the observation, comprehension and description of which require expertise
iv. evidence of fact given by an expert, which does not require expertise for its observation, comprehension and description, but which is a necessary preliminary to giving evidence in the other four categories
v. admissible evidence of a hearsay nature.

As to the fourth category, Hodgkinson and James say that, although it is not expert evidence properly so-called, it is often included within the loose definition of 'expert evidence' according to ordinary usage, so it is therefore worthy of inclusion.

It is clear from this classification that expert evidence of opinion is only one category of expert evidence. It is a misunderstanding perpetuated by the General Medical Council (GMC), Her Majesty's Courts and Tribunal Service and the Academy of Medical Royal Colleges that what is termed a 'professional witness', who gives evidence as to fact but not opinion, is to be distinguished from an 'expert witness' (Rix, 2021). But most of the evidence of fact likely to be given by a professional witness because expertise will be required for the observation, comprehension and description of those facts, is therefore a form of expert evidence. It falls into Category iii: 'Experts can and often do give evidence of fact… A skilled witness, like any non-expert witness, can give evidence of what he or she has observed if it is relevant to a fact in issue' (*Kennedy v Cordia (Services)* LLP [2016] UKSC 6).

Expert evidence of fact falls into three sub-categories:

(a) what the expert has observed in the particular case

(b) 'an expert may say what he has observed in other cases and what they have taught him for the evaluation for the facts of the particular case' *(Aktieselskabet de Danske Sukkerfabrikker v Bajamar Compania Naviera* SA [1983] 2 LI R 210)

(c) he may refer to 'his or her knowledge and experience of a subject matter, drawing on the work of others, such as the findings of published research or the pooled knowledge of a team of people with whom he or she works' (*Kennedy v Cordia (Services)* LLP [2016] UKSC 6), including 'the views of others, including work colleagues, so long as he records where he went for that advice' (*R v Pabon* [2018] EWCA Crim 420).

In addition to the above, the subject matter can also be a description or explanation of a specialist practice or practices (*United Bank of Kuwait v Prudential Property Services Ltd* [1995] EGCS 190 CA) such as, for example, the mental state examination, an aetiological 'formulation' or the process of 'structured clinical judgment' applied to risk assessment.

What is an expert?

The word 'expert' is a term of art in law and there is no statutory definition. It derives its meaning from the common or case law of a number of jurisdictions whereby, in order to provide expert evidence, the expert must be expertly 'competent' to do so – their competence derives from their 'skill'. In Scotland, the term used is not 'expert witness' but 'skilled witness'.

It is knowledge and skill, not status, which defines expertise. This is an important point to make because the GMC's expert in the case of *Pool v General Medical Council* [2014] EWHC 3791 (Admin) set out a number of status-based tests which are both excessively restrictive and wrong in law.

A psychiatric expert does **not** need to:

1. be on the GMC's specialist register in the appropriate area
2. have Membership or Fellowship of the Royal College of Psychiatrists
3. be a consultant of 20 years' experience
4. have held a substantive NHS consultant post
5. have published in the field of expertise in any form, or
6. have any special standing professionally among their peers.

These are **not** tests to be found anywhere in textbooks or academic texts on the law of evidence and none has been adopted in any judgment dealing with the admissibility of expert psychiatric evidence.

The test of who is an expert is simply what Lord Reed and Lord Hodge referred to in Kennedy as 'the necessary knowledge and experience'; or, as it was put in *R v Bonython* (1984) 38 SASR, the witness should have 'sufficient knowledge of the subject to render

his opinion of value in resolving the issues before the court'. But do not attach too much significance to the word 'and' in the *Kennedy* judgment. Although, as already pointed out, there is no statutory definition of an expert, the Civil Evidence Act 1972, s4(1) comes close to providing one and it refers to how expertise might be derived from 'knowledge or experience'.

What this means is being competent to assist, a 'skilled person'… who has by dint of training and practice, acquired a good knowledge of the science or art concerning which his opinion is sought' (*R v Bunnis* (1964) 50 WWR 422). And it is possible 'to acquire expert knowledge in a particular sphere through repeated contact with it in the course of one's work, notwithstanding that the expertise is derived from experience and not formal training'. Thus, an early example is that of a solicitor who was accepted as a handwriting expert having acquired the knowledge and experience studying church registers in his hobby as an amateur genealogist (*R v Silverlock* (1894) 2 QB 766). In *Shaw v DPP* [1962] AC 220, CA, expert evidence was given by members of 'the oldest profession' in the world. Experience alone qualified the prostitutes who assisted the court as to the meaning of certain abbreviations used in a prostitutes' directory.

Much of this case law is reflected in the definition of an expert given by the Crown Prosecution Service (2006):

> "a person whose evidence is intended to be tendered before a court and who has relevant skill or knowledge achieved through research, experience or professional application within a specific field sufficient to entitle them to give evidence of their opinion and upon which the court may require independent, impartial assistance."

But this applies equally to expert witnesses who give expert non-opinion evidence.

Knowledge and/or experience are *necessary*, but they are not *sufficient.* Hodgkinson and James (2015) state that the two most important qualities of the expert are the possession of knowledge of the specialism in question and an ability to *use* that knowledge. By using knowledge and, of course, experience they are referring to use in the assistance of the court. Someone may possess considerable knowledge or experience but lack the ability to communicate it in the form of a written report or orally in a court of law. That is, they must have not only clinical but also clinico-legal skill, based upon knowledge of relevant law and legal process. As the fitness to practise panel stated in *Pool*:

> "… to put oneself forward as an expert witness requires more than clinical experience and knowledge. It also requires the ability to produce an adequate report and to give oral evidence in an authoritative and convincing manner."

The expert has to be able to relate their clinical opinion to the legal definitions, tests or questions at hand; and then be able to communicate their knowledge and experience in a way that is intelligible and convincing, as well as being robust enough to withstand testing under cross-examination.

The current legal approach to expert witness work therefore supports the principle that, beyond being skilled as a result of knowledge, training or experience in a particular medical domain, there is "expertise in being an expert witness" (see Lord Woolf's *Access*

to Justice – Final Report, 1996). This includes being able to demonstrate an adequate understanding of the role and responsibilities of the expert witness; understanding and following of the laws, rules and codes of practice that govern the role of the expert witness; and, as indicated above, to be able properly to apply the relevant knowledge to the legal definition or test at hand, plus the ability to communicate effectively in a legal setting.

Admissibility

The courts decide whether expert evidence is required (therefore potentially admissible), as being 'relevant' to an issue(s) in the case; and, if it is, whether a particular 'expert' is qualified by knowledge, training or experience to assist by providing that relevant evidence. As indicated, this test of admissibility will usually consist of evidence that the expert has knowledge or experience of the disorder or issue at hand, acquired either through training, clinical practice or research. In practice, however, as Hodgkinson and James comment:

> "the most effective way of assessing expertise is, rather than conducting a difficult exercise based almost entirely upon the limited evidence as to qualification, experience and skill at the admissibility stage, to hear the witness's substantive evidence and use this as the basis upon which to judge not only the quality of his evidence, but his competence to give it".

The courts also impose a duty to assist by way of independent, objective and unbiased opinion upon matters within their expertise (see the 'Bias' section). This can be challenging for a psychiatrist who purports to give testimony on a patient already professionally known to them; and such relationship must be made clear to the court (see p23).

Identifying oneself as a potential expert

Whether or not a psychiatrist has the appropriate or relevant expertise for a particular case is initially for the parties, and ultimately for the court or tribunal, to decide. However, in making this ultimate decision, the court of tribunal has to be able to rely upon information provided by the expert; and in the criminal jurisdiction there is a requirement under the Criminal Procedure Rules for the expert to define their area or areas of expertise (r 19.2(3)) and to give details of their qualifications relevant experience and accreditation (r 19.4(1)(a)).

Defining one's expertise

The Forensic Science Regulator provides some helpful advice in their Expert Report Guidance.

The section 'Qualifications' includes:

> 'The provision of qualifications and experience in an expert's report is to support the claim to expertise. The listing of memberships of organisations should be considered in that context.' (10.3.19).
>
> 'The membership of an organisation which is obtained solely by applying for membership (and perhaps, payment of a fee) is not a qualification. This is true even if the holding of some other qualification (e.g. a degree), or some period of experience, is a prerequisite to making the application.' (10.3.20)
>
> 'The membership of an organisation can only be considered a qualification when conferring the membership, or the specific class of membership, is based on an assessment involving evaluation of the professional conduct and/or performance of the applicant.' (10.3.21)
>
> 'Consideration must also be given to the nature of the organisation. Listing membership of organisations which do not have some form of official standing to grant qualifications (e.g. by grant of a Royal Charter) is of limited value. (10.3.22)
>
> 'Listing of memberships of organisations which do not amount to qualifications in reports is, at the least, irrelevant and may be misleading. The same is true of the use of post nominal letters.' (10.3.23)

So far as experience is concerned, the Forensic Science Regulator states:

> 'The witness must give a fair and balanced picture of their experience and not only refer to positive comments in judgments etc.' (10.3.15)

> ‘Consideration should also be given to the following information which may be of use to the (Criminal Justice System).
>
> f. The nature of the cases the witness has dealt with.
> g. The types of evidence given.
> h. The courts involved (e.g. magistrates’ courts, Crown Court or appellate courts).
> i. Whether the witness tends to work for the prosecution, defence or both.
> j. Whether the witness has been the subject of criticism and is aware of that criticism. (10.3.18)

In terms of ‘accreditation’, the Forensic Science Regulator states:

> “In the context of the Rules the term must… be interpreted to have a wider meaning such as the official recognition of someone as having a particular status or being qualified to perform a particular activity.”

Therefore, for psychiatrists this means making reference to GMC specialist registration/ certificate of completion of higher specialist training and approval, for example under the Mental Health Act 1983, s12.

In many cases a curriculum vitae (CV) should provide information sufficient to demonstrate required expertise in terms of qualifications, experience and accreditation. This should include the year of qualification as a doctor, the dates of postgraduate qualifications, section 12 status, specialist registration identifying the particular psychiatric specialty or specialities, posts and positions held, publications and, where applicable, contributions, for example, to Royal College of Psychiatrists reports, committees of inquiry, such as homicide inquiries, and reports for health or prison ombudsmen.

The significance of the *Pool* judgment

The judgement in *Pool* (see above) gave rise to much concern amongst psychiatrists, both senior and those in higher training, plus their supervisors, in respect of what criteria the courts deem relevant to determining whether a doctor is, in fact, ‘expert’. This, ultimately misplaced, concern arose from the evidence that the GMC’s expert gave to the Tribunal, for example that the doctor must be in the ‘relevant’ category on the GMC’s specialist register. However, if this were properly to reflect the law defining what is ‘expertise’ (and it does not) quite clearly there would be cases within which more than one area of specialisation, and therefore GMC category, is relevant, as well as cases in relation to which it is not obvious what is the relevant GMC speciality.

The same expert also argued that, in order to be ‘expert’, a doctor had to be, or have been, a consultant. If correct, this restriction would clearly inhibit higher trainees in forensic psychiatry (some others also) from attaining key competencies that are required for satisfactory completion of higher training, as defined both by the College and the GMC. Rather than accept and apply the proper legal definition of expertise, the expert purported to suggest an (erroneous) medical definition. Notably, the GMC New Curriculum for Forensic Psychiatry includes the express requirement for forensic

trainees (surely also seniors) of gaining both 'knowledge' of a wide range of relevant law and also 'capabilities' that are not only clinical but also 'clinico-legal'.

The decision in *Pool*, properly interpreted, rested upon judicial factual consideration of the actual 'knowledge and experience' of Dr Pool; and did not in any way change the law of expertise: the court did not accept the criteria proposed by the expert appointed by the GMC. Thus, the correct law remains in terms (*Kennedy v Cordia (Services) LLP* [2016] UKSC 6):

i. whether the proposed skilled evidence will assist the court in the task
ii. whether the witness has the necessary knowledge and experience
iii. whether the witness is impartial in his or her presentation and assessment of the evidence
iv. whether there is a reliable body of knowledge or experience underpinning the expert's opinion.

The significance of the specialist registration

Clearly great care does need to be taken in explaining the training, qualifications and experience that are the bases of the doctor's specialist registration; and in explaining why training, qualifications or experience outside that speciality may be appropriate in a particular case. Hence, although a doctor's category of specialisation on the specialist register may be *evidence* of achieving skills and a particular level of competence, it is not probative of it; since, for example, the skills may have been acquired many years earlier, and to have decayed: and many doctors, over their careers, move practice and acquire considerable expertise in areas not recognised by their category on the specialist register, but evidenced through their continuing professional development and the processes of appraisal and revalidation.

Hence, for example, in some cases involving older persons the most appropriate expert may be a psychiatrist whose speciality is old age psychiatry; but in some such cases the most appropriate psychiatrist may be one whose speciality is forensic psychiatry. In the case of an older person with a learning disability (or an intellectual disability) who is involved in criminal proceedings, the most appropriate expert might be an old age psychiatrist, a forensic psychiatrist or a learning disability (intellectual disability) psychiatrist. In a personal injury case involving a working-age adult, the relevant specialty might be general psychiatry or forensic psychiatry. In many cases there is a preference for forensic psychiatrists because their forensic skills are regarded as desirable, if not necessary, when evaluating evidence and addressing legal tests, but this preference may be based upon misunderstanding, or under-estimation, of the analytical skills of some psychiatrists who are not forensic psychiatrists.

Again, the doctor needs to be clear as to the setting in which they work, or have worked (but see also concerning 'recency'). A psychiatrist who works in an in-patient setting, for example, and who has had no sufficiently recent experience of working in a community setting may be considered as lacking expert knowledge of community patients. This may not matter if the issues are the same regardless of the setting, but if the point is arguable then the psychiatrist should set out the reasons why they consider that they

are qualified to provide an opinion in relation to a person being assessed who is in a different setting from that in which the psychiatrist works.

Given the need for knowledge, skill and experience in applying clinical information to legal tests relevant to the case at hand, a psychiatrist might properly exclude himself by way of lack of such experience (see *Kumar v General Medical Council* [2012] EWHC 2688 (Admin) in which a consultant general psychiatrist undertook a murder case involving 'diminished responsibility' without any relevant *clinico-legal* experience and was suspended from the Medical Register by the GMC for a period).

The dialogue with the instructing party

The potential expert ought also to disclose any information that could significantly detract from their credibility as an expert, which includes judicial criticism and any complaint upheld by the GMC or the MPT. Notably, in criminal cases the parties are under an explicit duty to disclose such information.

The foregoing list of types and levels of experience is not exhaustive. The provision of a full, detailed and accurate CV should be only the starting point of a written dialogue with the instructing party concerning the relevance and sufficiency of the psychiatrist's training, qualifications and experience for the particular case. Hence, the psychiatrist must ask, before accepting instructions, for sufficient information about the nature of the case and the issues to be addressed in order to be able to take an informed view as to whether they can validly be seen as 'expert' or as 'the right expert' (or, indeed, the 'best type of expert'). The psychiatrist should ask whether there is any further information, or any clarification, that they can provide to ensure that the instructing party can be sufficiently confident that they have identified an (or the) appropriate expert.

Hence, before finally accepting instructions, the psychiatrist should ask the instructing party to confirm that they are satisfied, for reasons clearly identified, that they have the necessary training, qualifications and experience. It might also be advisable for the psychiatrist to state that, if the instructing party has any doubt as to the appropriateness of their training, qualifications or experience, they should make this clear. This should all help the psychiatrist to avoid giving evidence on matters outside their area or field of expertise.

Appropriately trained professionals are required to provide expert testimony in relation to children and adolescents in the criminal jurisdiction as well as in the family and civil jurisdictions. Psychiatrists who prepare reports for the courts in relation to children and adolescents under 18 years of age must be able to show that they have appropriate training and expertise, especially with regard to developmental matters and child-specific matters. Evidence of such training and experience includes specialist registration by the GMC in the category of child and adolescent psychiatry

If a psychiatrist is *uncertain* as to whether they are an appropriate expert then it may be advisable to seek the advice of a peer group member or a medical defence organisation (MDO).

If a psychiatrist has any persisting doubt as to the sufficiency of their training, qualifications or experience for a particular case, they should err on the side of caution and decline the instructions.

Assessing expertise as a preliminary issue

Sometimes a court or a tribunal needs to deal with the appropriateness of a proposed expert as a preliminary issue, as happened in the case of Dr Pool; and so, it may hear evidence from the psychiatrist as to their training and experience. In such a circumstance, it is important for the psychiatrist not to feel that their expertise as a psychiatrist is being challenged. Even if the format is adversarial, with the parties' representatives, as well as the judge, chair, or legal assessor asking searching questions, the psychiatrist should see the process as necessary inquiry on the part of the court or tribunal in order to assist it in identifying the right expert; and where appointing the wrong expert might result in delay, added expense and, at worst, injustice or damage to the psychiatrist's reputation.

Pressure to step outside your field of expertise

It is not unusual for courts of any sort to ask doctors questions that are outside their expertise and more properly the province of a different expert witness. Thus, psychiatrists giving evidence need to be clear what role they are performing in court and, where appropriate, be prepared respectfully to advise the court that the question would be more properly addressed to another expert, or that it is outside their area of skill or knowledge. In coroners' courts, mental health tribunals, childcare proceedings and criminal courts, doctors are often pressed in this way. If so, pressed by a judge or coroner to answer, then the psychiatrist might decide to do so, although it would be wise to reiterate that they are answering reluctantly, and to acknowledge the conflict with professional guidance.

Establishing and maintaining expertise: support, appraisal, revalidation and licensing

Support

The Family Justice Council's (FJC) *Working Group on Medical Experts Final Report* (2020) refers to a finding that 62% of respondents did not feel supported by their medical royal college or professional association to complete expert witness work. The support of employers, the College and peers is crucial to successful practice as an expert psychiatric witness. The FJC is going to be working with the NHS to promote better support of expert witness work carried out by NHS staff. The College, in response to the FJC working group's recommendations, will be appointing an expert witness lead to support College members who are, or might be encouraged to become, expert psychiatric witnesses. The College's peer group system lends itself to the creation of medicolegal peer groups in which members can support each other as well as peer review cases, keep up to date and advise each other as to CPD that will inform and enhance their expert witness practice.

Appraisal

Appraisal directed towards revalidation requires that all aspects of a doctor's work be assessed. And it is the responsibility of the 'responsible officer' reporting to the GMC to ensure that all such work has come within the appraisal process, including work conducted outside of any contract of employment with the organisation within which the responsible officers sits.

Hence, there is a duty on psychiatrists who give expert testimony to ensure that such work is included in their appraisal towards revalidation (e.g. multi-source feedback such as the College's Multi Source Assessment for Expert Psychiatric Witnesses (MAEP) is based on responses from the instructing lawyers, counsel, the other party's expert(s) and potentially from counsel and judge on the quality of oral evidence). There is also a duty on them to show that they have maintained their skills and competence in their field of expertise. They must be able to show to their responsible officer that they have demonstrable expertise in the field or fields claimed. Such requirements are now included in the standards for expert

witnesses in children proceedings in the family court, Practice Direction 25B (Lord Chief Justice, 2014).

It follows that expert witness work must, in its own right, be the subject of appraisal and revalidation, informed by the panoply of processes such as MAEP and case-based discussions of expert witness cases. Practice within a 'chambers model' provides a good overall context for assessment of an expert's skills, where it includes case-based discussions with others experienced in expert witness practice.

Licence to practise

It has sometimes been suggested that it might not be necessary to hold a licence to practise in order to undertake expert witness work. However, since the basis for being permitted to give expert evidence is through the exercise of clinical skills, that suggests that good practice requires that such skills be subject to appraisal, and possession of a licence to practise is evidence of this. Indeed, the standards for expert witnesses in children proceedings in the family court, Practice Direction 25B (Lord Chief Justice, 2014) explicitly include a requirement for the medical expert to hold a licence to practise, if their current professional practice is regulated by a UK statutory body.

The present position of the MDOs is as follows.

The Medical and Dental Defence Union of Scotland (MDDUS) requires its members to hold a licence to practise for medico-legal work. The only exception is where a doctor, as an existing member, is approaching final retirement and running off cases and in that event only when this work does not require or involve direct 'patient' contact, and in addition only when the MDDUS has expressly agreed this concession. Its advice to doctors who are considering giving up a licence to practise but intend to continue medico-legal work is that they must have a licence to practise if they intend to undertake any direct 'patient work' (as opposed to review of records) and that they must inform bodies that instruct them and the court if they no longer hold a licence to practice. .

The Medical Defence Union (MDU) currently advises members that they would be wise to maintain a licence to practise should they choose to continue undertaking medico-legal work which involves:

1. The assessment of a patient's condition and/or prognosis. (This is regardless of whether members choose to do so in person or provide an opinion on current condition and future prognosis based on information contained within papers/records provided.)

2. Providing an updated opinion in respect of condition and prognosis on matters when members would have previously provided a report or opinion.

3. Any examination of an individual regardless of whether there is any treatment involved.

However, a licence to practise is not required if MDU members choose to confine their opinions to issues on paper in respect of breach of duty and/or causation. If a member

wishes to undertake medico-legal work without a licence to practise, it can continue to indemnify them for this work provided they limit their opinions to matters of causation or breach of duty relating to the examination, condition, diagnosis or treatment of a 'patient'. The benefits of membership are unlikely to extend to assist with any expert work involving the examination of a 'patient' and/or the provision of a new (or updated) condition and report where a member does not hold a licence to practise. This includes condition and prognosis evidence given in court or at a joint meeting of experts.

The Medical Protection Society will not cover an unlicensed doctor where the legal issue under consideration is 'condition and prognosis'.

Where a psychiatrist uses clinical history-taking and examination skills in the course of a medicolegal assessment, it is the position of the Royal College of Psychiatrists that it would be ethically, even if not legally, unwise to do so without holding a licence to practise. Indeed, notwithstanding the positions the medical defence organisations may adopt, which are determined by insurance and indemnity considerations, the College's position is that, other than exceptionally (see below), psychiatrists who provide expert evidence, even in cases where there is no clinical contact in the form of history-taking and examination (such as in the preparation of some 'breach of duty' and 'causation' reports), should hold a licence to practise.

The possession of a licence also gives some assurance, via appraisal, that the psychiatrist is up to date with their continuing professional development and in a good standing.

Recency of experience

The psychiatrist should also be able to demonstrate that they are active, clinically or academically, in the particular area of practice, or have been so sufficiently recently to allow for knowledge of any developments in the area, or otherwise have sufficient experience of the issues. This should be reflected explicitly in the psychiatrist's CV in order to inform the dialogue between potential expert and instructing solicitors that is necessary to ensure that the court gets the right expert.

Where the expert evidence does not relate to clinical care, the requirement of 'recency' might not apply in the same way; for example, where assessment is essentially in terms of diagnosis or solely applied to such issues as criminal culpability or responsibility. Also, exceptionally, for example in a case of alleged medical negligence, the most appropriate expert might be a retired and no longer licensed psychiatrist who was in practice at the time of the alleged negligence.

Training as an expert witness

As a core part of their training, specialist forensic psychiatry trainees are required to acquire knowledge and skills concerning law and the interface of law and psychiatry, as specified in the New Curriculum (Eastman and Hind, 2021). They should therefore undertake report writing, but only under direct consultant supervision. Their report should make this plain, and also clearly identify the supervisor and their supervisory relationship. The supervisor may be a clinico-legal supervisor and not the trainer responsible

for their clinical training. The supervisor also needs to be fully aware of their own legal responsibility for the report's accuracy, reliability and validity. Where trainees give oral testimony, ideally their supervisor should be present in the tribunal or court in order to provide feedback at the conclusion of their evidence. This may be difficult to achieve but it is such an important aspect of supervision and training that the commitments of both the trainer and the trainee should be taken into account when listing the case.

Notably, the competencies that higher forensic trainees are required to achieve, as defined by the College, including receiving and negotiating instructions to prepare a report and preparing reports for courts of law, specifically coroners', criminal and civil. Higher specialist forensic trainees will benefit from attending training specifically focused on being an expert witness, such as the courses run by the Academy of Experts, the Expert Witness Institute, the Royal Society of Medicine, the Royal College of Psychiatrists, the Inns of Court, and Bond Solon; and observing their supervising consultant giving written and oral evidence in criminal cases. Giving oral evidence at mental health tribunals will likely provide 'first opportunities' to develop in this area.

Training can also be 'quasi-experiential' by use of 'cases on paper' (Eastman et al, 2019) conducted either individually or jointly through 'psycho-legal workshops'.

Rix, Eastman and Haycroft (2017) have set out in detail approaches to training in the preparation of expert psychiatric reports and these have been summarised in Rix et al (2021) as follows:

- Prepare an expert 'opinion' based on one of a library of reports covering the range of commonly encountered issues in their speciality and from which the opinion section has been removed. This can be carried out as a group exercise; prior to the group discussion, trainees can exchange and assess each other's opinions.
- Attend a medicolegal consultation with supervisor and draft a report based on the consultation and consideration of all documents and materials available to the supervisor.
- Conduct a medicolegal consultation under the direct observation of the supervisor and draft the consultant's report ('ghost report') incorporating any additional information elicited, or signs identified, the by the supervisor.
- Conduct a medicolegal assessment 'solo' and present history and examination findings to the supervisor, who should verify them; then draft the supervisor's report ('ghost report') incorporating any information elicited, or signs identified, by the supervisor.
- Conduct a medicolegal assessment 'solo' and prepare a report in own name and counter-signed by the supervisor who can, if necessary, arrange to clarify or confirm the trainee's findings.

Arrangements may be made for trainees to familiarise themselves with court procedure and the giving of evidence by what is termed sitting on the bench as a 'judge's martial'. Opportunities should be taken to shadow consultants who are giving evidence including attending conferences with counsel. Experience of giving evidence at a mental health tribunal is invaluable but on its own it is not sufficient training for giving expert evidence in courts and tribunals.

Finally, expert witness work should not be taken up *de novo* after retirement without training and mentoring.

Negotiating instructions

In terms of both ethics and law, psychiatrists have a duty not to give evidence or opinion on matters outside their areas or fields of expertise, as well as a duty to give an account of a full range of opinion, or reasonable opinion, on any issue, using the best-quality empirical evidence. It is therefore their duty to include an account of any evidence, or its interpretation that goes against their opinion.

The expert should not take instructions that go beyond psychiatric expertise and evidence-based data, for example, responding to a request to determine whether an individual is telling the truth or diagnosing a novel psychiatric condition for which there is no evidence base.

The standard for assessing the reliability of psychiatric testimony has not yet been tested in the courts. However, as the recently amended Criminal Procedure Rules, by way of their amended Practice Directions, have imported the reliability tests proposed by the Law Commission (2009), it seems reasonable to advise psychiatrists to use the 'established psychiatric practice' test. This is because one of the tests is: 'whether the expert's methods followed established practice in the field and, if they did not, whether the reason for the divergence has been properly explained' (CPD V Evidence 19A.5 (h)). In discussions of this matter, as part of the Law Commission's working group, one of the writers of this report (Nigel Eastman) suggested that this factor, in tandem with the need for the expert to provide an opinion as to why their opinion is sound, summarises 'particularly well what should be the approach to medical evidence which is psychiatric in nature'.

The use of this 'test' implies, of course, that the expert should conduct his own comprehensive clinical assessment, and not merely 'test the quality of the assessment of another expert in the case' (which amounts to an 'adversarial' and not 'medical investigative' approach).

The duty of impartiality requires the psychiatrist to justify and explain any modifications they have made to ordinary clinical interview or other assessment technique.

The best ethical and legal guidance advises that it is the duty of any psychiatrist to assist the court to 'effect' justice and never to seek to 'affect' it. Hence, psychiatrists need to be able to reflect upon how their own values might influence the opinions they give, to the detriment of their 'honesty' in giving such opinion in that values can, indeed arguably will inevitably, be expressed within clinico-legal method and decision making (see the 'Bias' section).

Psychiatrists will likely need to decline instructions in cases where they have competing or conflicting interests – and commissioners and potential treating doctors will need to liaise at an early stage to address any conflicts in advance. Psychiatrists who act as experts have duties additional to their general ethical duties: namely, to be honest, impartial and as objective as possible in any legal context.

There have been recent attempts by the legal system to improve the quality of instructions

to experts. Experts should say if they consider instructions to be insufficiently clear and it is open to experts to refuse to take instructions that remain poorly worded or unclear. Instructing solicitors often welcome advice about how best to set out the questions on which an expert can comment.

Experts should also consider whether they can complete the report in the time given. They should say if the time frame is unrealistic and refuse the case it is likely that they cannot comply with the time set. Where people involved in legal actions are adversely affected by experts who cause delays, those experts may be at risk of financial penalties such as via a wasted costs order.

The treating psychiatrist as expert

The general rule and its exceptions

International codes of ethics generally advise against the treating clinician giving expert testimony within litigation involving their patient. This is because of the potentially negative effect upon the therapeutic relationship and/or because of the risk of bias or the perception, or accusation, of bias, with the distinction between 'patient' and 'defendant' or 'litigant' being central. For these reasons, it is generally good practice, with some specific exceptions, for treating psychiatrists not to provide expert testimony about their patients. The GMC impliedly advises the same stricture by reason of its guidance Acting as a Witness in Legal Proceedings where the different roles of an expert witness and a treating physician, who may act as a 'professional witness', are set out.

A specific exception applies in Ireland where it is normal practice for the treating doctor to prepare the report for personal injury litigation. In highly specialist fields of clinical care such as forensic psychiatric practice and secure care of some groups of patients, this guidance may be impossible to adhere to, either for practical reasons or because law effectively requires such evidence (for example, in regard to sentencing recommendations under mental health legislation).

Hence, the need for confidence in impartiality sometimes needs to be weighed against the need to have the best-informed professionals commenting, especially upon care. Particularly, forensic psychiatrists working in secure settings may have long-term relationships with patients who are also defendants in criminal trials and they may be the appropriate expert in relation to catchment area placement and treatment resources. There may also be human resource problems in highly specialised fields, where it is not practicable to separate 'treating psychiatrist' from 'expert witness'.

The case of *R v Nelson* [2020] EWCA Crim 1615 is an example of a case where, upon appeal against the imposition of a hybrid order, the admission of evidence from the patient's treating psychiatrist, about his progress over the years since sentence, and the plans for his future care, underpinned the court's substitution of a hospital order with restrictions on discharge.

However, in relation to evidence on trial issues, for example, 'diminished responsibility' in a murder trial, it is usually likely to be advisable that the treating clinician does not accept instructions as an expert for either side. And, of course, an independently instructed expert will have access to all the treating team's records and opinions (sometimes conflicting within the team).

The situation is therefore complex in relation to forensic patients and services.

The circumstance of the mental health tribunal

At mental health tribunals, an expert psychiatric witness needs to be aware of what is often a fundamental conflict between the stated interest of the patient who wants to be discharged and the duty of the treating psychiatrist, whose role is often to argue in favour of the patient's continued detention (although in cases of patients subject to restrictions on discharge they may be arguing for a discharge). On the one hand, the treating psychiatrist has a duty to assist the tribunal, but on the other they have to maintain a positive therapeutic relationship with a patient with whom they must continue to work constructively once the hearing is concluded.

There is a further potential for a conflict of interest if the treating psychiatrist fulfils the role of the representative of the detaining authority. It is no longer the case that automatically the responsible clinician does do so (see R *(on the application of Mersey Care NHS Trust) v Mental Health Review Tribunal* [2003] EWHC 1182 (Admin)), thereby giving them a right of 'cross-examination', but this can still occur. It is therefore important that the responsible clinician makes clear at the outset of the hearing that they do not represent the detaining authority (or, that they do, on such rare occasions). Where conflicts of interest cannot be avoided, being open and explicit about them is likely to defuse many potential problems and the GMC mandates disclosure (see Acting as a Witness in Legal Proceedings; paragraph 23).

Responding to requests

Where a psychiatrist is asked to prepare an expert report on a patient in, or previously in, their care, it may be helpful to consider the following questions:

- At the outset of my involvement with this patient, was I in a position to obtain their consent to produce an expert witness report, and did I obtain that consent?
- Does the patient now consent to my preparing a report for legal proceedings?
- Do any conflicts arise between my duties to my patient and to the court?
- Do these conflicts prevent me from fully complying with my duty to the court?
- Is it possible to restrict myself to specific issues that do not cause conflict?
- Would an independent expert be preferable for any of the instructions that are intended for me?

The police sometimes ask treating consultants for a 'capacity assessment', usually having in mind the patient's fitness to plead and stand trial or their mental state at the material time in relation to a mental condition defence. The police can appear to think that, if the patient is unfit to plead and stand trial or likely would have a mental condition defence, this is a reason for not proceeding with the investigation. It is often necessary to point out that these are considerations that should be addressed later in the investigatory process as (a) they are offence specific and (b) they require expert opinion that is independent from the team providing care for the patient.

It is not uncommon, when a potential crime is reported to the police, for an inexperienced police officer to say that there is no point in investigating the case or interviewing

witnesses or the suspect because “they will get off with insanity” or “they won’t be fit to plead” or even to suggest that there is no point in charging someone because they are already detained under mental health legislation.

It is therefore also necessary in some cases to explain how the enhanced measures for public protection, where there is a risk of serious harm to the public, can only be deployed if the person is charged with a criminal offence. Such measures are available in the form of a restriction order, whether upon a finding of unfitness to plead or upon a verdict of not guilty by reason of insanity or upon conviction.

The ethics of being an expert

The expert's overriding duty

There is no doubt that, as a matter of ethics and law, the overriding duty of the expert is to the court and to the administration of justice (see for example, the Civil Procedure Rules r 35.3, the Criminal Procedure Rules r 19.2(2) and the Family Procedure Rules r 25.3).

As already indicated, psychiatrists called as experts have both ethical and legal duties to assist the court in its deliberations and there is certainly no duty to assist the individual being assessed to win their case or to achieve what they regard as a good outcome. This is why the duty to the court overrides the duty to the instructing party. There is a duty to the court to work to both a high *clinical* and *clinico-legal* standard and to form an opinion fairly and honestly about matters relevant to the issues in question. There is also a duty to the instructing party which may include, for example, advising on the evidence needed to meet the opposing case.

The expert's ordinary clinical ethical duty

Psychiatrists cannot ignore their ordinary clinical ethical duties as doctors when evaluating individuals for the courts. In addition to dealing with the person they are assessing fairly and with respect, particularly towards their autonomy, they need to have regard to the person's welfare (beneficence) and to the prevention of harm (non-maleficence). Although the legal context is distinct from the medical one and has a different professional focus, the expert's application of their medical knowledge and skills may still engage their ethical duties of the doctor.

If they ascertain that the person they are assessing has a medical condition for which they are not receiving any appropriate or adequate treatment, they should inform the person and advise them to consult their ordinary medical practitioner. Reference to this advice should be made in the report. Additionally, as a safeguard for the expert, the report should include a recommendation that the person's ordinary medical practitioner be informed by those instructing the expert, as well as a request that the expert should be told if, for whatever reason, this advice is not followed.

Occasionally, the psychiatrist may consider it appropriate to communicate directly with the person's ordinary medical practitioner. This should be done with the person's consent and the psychiatrist should communicate only sufficient information for the doctor to act on the psychiatrist's findings; the expert report should never be disclosed. Except in cases of urgency, it is wise to advise the instructing solicitors before communicating with the person's doctor. In any event, a copy of the letter or email, or a note of the telephone call, should be provided to the instructing solicitor. Very exceptionally, for example where there is a risk of imminent serious harm to the person or others, or where the person lacks capacity to consent, it may be necessary to act without the person's consent or

the approval of the instructing solicitors (Royal College of Psychiatrists, 2010). If time permits, it may be advisable, in such circumstances, to take the advice of an MDO.

Any identified child protection or safeguarding issues should be clearly addressed, even though they may be beyond the issues about which opinion has been sought. The ordinary duties of disclosure applicable to such individuals will apply.

When children and young people are being assessed, consideration of psychiatric issues relevant to fitness to plead and how to promote their effective participation (in either criminal or civil proceedings) may also need to be actively considered, even when this has not been specifically requested by legal representatives. Other than in exceptional circumstances, psychiatrists who have not received specific training in child and adolescent mental health should not undertake assessment of a young person's fitness to plead, as this is a highly specialist area requiring considerable experience of child development.

If there are concerns that the expert's testimony could lead to a negative outcome for the person assessed (see the Potentially negative testimony section), the expert might wish to take steps to try to ensure that the person assessed has proper access to medical and psychiatric care and legal representation.

Consent

It is good practice for experts to obtain written consent for the preparation and disclosure of the expert report. The consent form, of which a copy can be given to the subject, can incorporate information about the nature and purposes of the assessment and the limits of confidentiality.

Litigants in person

Written consent obtained on a form that is part of a detailed document setting out the nature, purpose and potential consequences of the psychiatric evaluation may be particularly important in cases where, as a result of reduced legal aid funding, litigants act without legal representation. Such 'litigants in person' (LIPs) are increasingly common in the family courts. They are particularly likely to misunderstand the duties and role of the expert and may believe that they are 'buying' an opinion favourable to their case. A well-constructed and signed consent form can assist both the LIP and their instructed expert in the event of a complaint.

If it is apparent to the expert that a LIP lacks litigation capacity, the expert is under a duty to inform the court. The other parties and the court may not otherwise be aware of their incapacity. The court may then appoint someone such as a 'litigation friend' to act on their behalf.

Also in regard to LIPs, where this arises because of lack of legal aid funding in a family court, clinicians may consider themselves to be on the horns of a dilemma in that they

may find the lack of a legal intermediary to pose practical problems, and yet to refuse instructions from such litigants may result in their inability properly to obtain expert evidence that the court should hear and thereby deny them justice.

Justice delayed

It is a well-known aphorism that 'justice delayed is justice denied', and the courts' overriding objective of justice includes dealing with cases expeditiously. Therefore, the doctor's duty to the court determines that their report must be produced in a manner that not only addresses the questions asked by the court, but does so within a timescale that the court determines. This also applies to communications subsequent to the provision of the report.

Lack of capacity and best interests

One particular difficulty which may arise is when a person being assessed as so mentally unwell that they lack capacity even to consent to the assessment. In such circumstances, the relevant mental capacity legislation should be applied (e.g. in England and Wales the Mental Capacity Act 2005) and every reasonable effort made to assist the person in re-gaining the requisite capacity. This should include consulting with those involved in their care. If they still lack capacity, then a 'best interests' decision should be made which may well conclude that an assessment should be carried out.

It has been recognised that "The word 'interests' in the phrase 'best interests' is not confined to matters of self-interest or, putting it another way, a court could conclude in an appropriate case that it is in the interests of P for P to act altruistically" (*Re G (TJ)* [2010] EWHC 3005 (COP)). If the person is involved in a dispute that has engaged the public interest, in answering such questions as 'did they commit the crime alleged?', 'have they been wronged by the other driver/the hospital?', 'have they been the subject of discrimination?', the public interest in the administration of justice is on a par with altruism and is therefore something that can be taken into account. It is also relevant to consider the likelihood that, in their right mind, the subject would say that they wanted the litigation to move forward notwithstanding their incapacity. For this, there is also support in case law, specifically from a case where the court recognised the desire of the patient, had he or she been capable, to be seen to be "a normal decent person, acting in accordance with contemporary standards of morality" (*Re C (Spinster and Mental Patient)* [1991] 3 All ER 866). For 'contemporary standards of morality' read 'the rule of law and the processes of the administration of justice'.

Where the subject unreasonably objects to the preparation of a report and does not lack the capacity to consent, other than where a court has ordered the report, probably the only basis upon which a report can be prepared is if there is a risk of serious harm or death to the subject or others; and the risk cannot be managed other than by carrying out and appropriately reporting the results of an assessment.

Bias

The expert witness practice of doctors is under constant scrutiny by the courts and the GMC and the possibility of bias (Eastman and Rix, 2021) should be addressed within appraisal for revalidation as part of the review of a doctor's overall practice.

Expert witness practice bias can be addressed in terms of its sources and routes to expression. 'Adversarial' bias can arise from the fact of instruction by one side; from the fact of a 'relationship' with a defendant, litigant, or lawyer; or as an effect of the adversarial process of inquiry itself (e.g. via conflict between investigative and adversarial method). Cognitive heuristics and bias, including giving expression to personal values, are both ubiquitous and inevitable in some measure. Pursuing honesty through ethical insight is crucially important.

Regulation and appraisal of expert witness practice must address not only technical competence, including demonstration of a real understanding of the interface between medicine and law, but also ethical probity – particularly regarding bias – which is the most challenging appraisal focus. This is especially because within psychiatry, there is much room for 'values expression', and therefore bias, in the offering of expert opinion which can potentially result in 'base line drift', the risk of which being enhanced where an expert operates in practice isolation and in the absence of informed peer review.

Other ethical issues

Detention conditions

If experts have concerns about the conditions in which a person being assessed is held, then they should report this to the official responsible for the detention placement and to those who provide medical cover to the establishment. However, they should still carry out the required evaluation, in the interest of the justice process, unless the circumstances would invalidate the assessment.

Reports that are not based on a direct assessment of the subject

Psychiatrists may occasionally be asked to prepare reports without consulting with, or otherwise directly assessing, the subject of the report. These may be on individuals who will not attend for assessment. This will often be ethically justifiable because it assists the court to achieve justice in the case. Except where the expert's opinion is sought outside the litigation process, for example in commenting on another expert's report, such a report should not usually be prepared without:

- either the consent of the subject of the report
- the agreement of the parties to the litigation
- or an order from the court.

Where there has been no personal assessment of the individual concerned, the report must make this clear. It should also state that the report is an expert commentary upon materials provided and not a psychiatric report about the individual as such. It is also advisable to point out that the psychiatrist is willing to consult with the subject of the report and, if appropriate, to amend their opinion in the light of their findings on assessment.

In some circumstances a psychiatrist may be asked not to provide a report for the court but to offer a critique of, or commentary upon, the report of another expert, in the role of an 'expert advisor' in a civil case. Effectively this amounts to, and should be headed, an 'advisory report'. It is not an 'expert report,' and this should not be confused with providing an independent opinion to the court.

This is justifiable on the basis that lawyers acting for one party have a right to obtain expert advice on the expert report of a doctor instructed by another party, given that the lawyers cannot know, for themselves, what errors or weaknesses there may be in the report. However, again, the preamble should make it clear that it is a report to assist in the understanding of the report on which it is based. Similarly, a psychiatrist in a criminal case may be provided with a defence psychiatric report and asked to comment upon it in order to inform a charging decision or to assist as to a defence that is

raised. Again, this should not be confused with providing an independent opinion to the court although it may become necessary for that assistance to be translated into expert evidence compliant with the Criminal Procedure Rules.

Testing the evidence

Clinical practice compared with expert witness practice

It is a proper and necessary part of ordinary clinical psychiatric practice sometimes to 'test' the history given by a patient and their account of their symptoms. However, such challenge must be directed solely towards the goal of 'the benefit of the patient' and pursued through 'beneficence' and 'non-maleficence' (Beauchamp and Childress, 2001). Further, the challenge must be both 'necessary' and 'reasonable' towards the goal of benefiting of the patient. The one exception to such a 'blanket' rule is where the patient might pose a risk to others. In which case, the ethical basis for clinical challenge is thereby widened, so as to take account of a duty of the clinician to others, within 'justice'.

However, by contrast with ordinary clinical practice, expert witness practice is directed not at the benefit of the defendant, claimant or other party to the litigation but at 'justice', represented by the justice process into which an expert report is served. It follows that 'clinico-legal testing' is deemed proper if, in its detail and application, it is both 'reasonable' and 'necessary' in order to assist the justice process. That does not, of course, mean that an expert assessing a litigant has 'carte blanche' to behave with the defendant or litigant as they may wish. Behaviour that is either 'not necessary' or 'not reasonable' towards assisting the administration of justice may still lay the ground for a complaint to the GMC about the expert's practice.

In the event of a complaint to the GMC (see the complaints and professional regulation section) about the behaviour of an expert instructed to assess a litigant, it should properly be adjudged according to the above principles, which are different from the principles properly applied to a complaint about 'clinical challenge'.

The GMC sets out its expectations in Acting as a Witness in Legal Proceedings, stating: 'You must take reasonable steps to *check the accuracy* of any information you give, and make sure that you include all relevant information' [our emphasis]. This is a specific example of the wider duty on all doctors under Good Medical Practice (para. 71) to take reasonable steps to check all documents including reports made.

Experts in Scotland are told by the Law Society of Scotland (2023): 'An expert witness should not provide the court with a statement of unqualified conclusions about the question of fact on which his/her opinion relies. If an expert witness does so, the effect of his/her testimony may well be diminished. It is therefore of the utmost importance that any expert witness carefully describes the source and *assesses the worth* of *all* material on which his/her opinion is based' [our emphasis].

Case law and forensic scepticism

A body of case law supports the exercise of such forensic scepticism. In *R (Minani) v Immigration Appeal Tribunal* [2004] EWHC 582 (Admin), the court held that "(i) it is plain that a psychiatrist does exercise his critical facilities and experience in deciding whether he is being spun a yarn or not"; and, in *MO (Algeria v Secretary of State for the Home Department* [2007] EWCA Civ 1276, the court said that a doctor was not to be criticised for assessing the credibility of the litigant, and "(i)indeed, sometimes it will be unfortunate if he does not, since then the fact-finder will be deprived of the benefit of the doctor's opinion that someone has proved to be an unreliable historian". In *Turner v Jordan* [2010] EWHC 1508 (QB) the judge observed:

> "A consequence of the fact that diagnosis in a psychiatric case depends on assessment of what is reported by the patient is the necessity for the psychiatrist confronted by a patient to consider whether or not to accept at face value what the patient reports. Inevitably there is a disposition on the part of the psychiatrist to take as genuine what the patient reports, because otherwise it is difficult to consider the issue of diagnosis."

Some of this, and much more, case law was reviewed in *MN v The Secretary of State for the Home Department* [2020] EWCA Civ 1746, where the court concluded:

> "There is no rule that doctors are disabled by their professional role from considering critically the truthfulness of what they are told. We would add that … a doctor's assessment of the truthfulness of the applicant may …. be of particular value".

The necessity for such forensic scepticism was recognised by a US court in *Mims v United States* 375 F.2d 135 (5th Cir 1967):

> "Expert opinion evidence may be rebutted by showing the incorrectness or inadequacy of the factual assumptions on which the opinion is based… Also, in cases involving the opinions of medical experts, the probative force of that character of testimony is lessened where it is predicated on subjective symptoms, or where it is based on narrative statements to the expert as to past events not in evidence at the trial."

Clinico-legal testing accords with both the guidance and the case law. But a balance is to be struck. In *Poole v Wright* [2013] EWHC 2375 (Civ), the court concluded that the evidence of the defendant's expert, who 'seems to have adopted the role of private investigator into the claimant's case', was not of a quality to assist the court. It was also the substance of a complaint to the GMC that a psychiatrist employed a private investigator to conduct covert surveillance on a police officer in a police pension case.

Clinical plausibility

If an expert is not going to accept at face value what the subject says, it follows that they have to:

a. assess clinical 'plausibility' (distinct from 'credibility'), which means asking sufficiently searching questions to decide whether the presentation 'fits' with the range of clinical presentations of the suspected condition, and
b. look for 'corroborative evidence' (which may include, for example, observation of the individual's presenting mental state; evidence from medical records; and evidence from legal papers in the case).

As Kennedy (2004) has stated:

> "…any clinician, and therefore any psychiatrist in the role of expert witness, can be wrong and can be deceived. In clinical practice, the psychiatrist's normal means of ensuring against being misled is never to rely only on the account of one person. Multiple primary sources of information, independent of the individual assessed, are essential."

It therefore follows that, in order to base an opinion as to diagnosis on subjective symptoms, the expert has to assess the worth of the evidence. Otherwise, they fall foul of the GMC for not taking reasonable steps to check the accuracy of the information in the report (as stated above). Of course, the expert has a duty to assess the worth of the subject's account in order that the court can decide what weight to accord the expert's opinion.

As to how far to go, it seems highly unlikely that clinico-legal challenge can properly extend to having the character of 'cross-examination'.

Potentially negative testimony

Experts sometimes give testimony that leads to negative outcomes for those upon whom they report. For example, in relation to sentencing for violent crime, an expert report might contribute to a judge's determination of the type and/or length of sentence in a number of ways, including: by way of the opinion they express on 'risk' or by virtue of the data they collect during assessment (or both); via evidence as to alcohol or substance misuse in connection with which the defendant has failed to respond to treatment may be taken into account as an aggravating factor; or, in a child protection case, via expert testimony which could contribute to the decision permanently to remove a child from their parents, which is often perceived by the parents as a negative outcome. Some psychiatrists may believe that giving such testimony conflicts with their ethical duty to benefit people they see and evaluate. However, often, or even usually, it will not be possible to predict the outcome until the evaluation is complete.

One perspective on this ethical tension has been to argue that those assessed for court proceedings are not 'patients'. Hence, several international codes of ethics have taken the view that since the expert's relationship with the subject of their assessment is not a therapeutic one, the subject (whether a party in the family proceedings, or a defendant in criminal proceedings, or a claimant in a personal injury case) is not a 'patient', so that their welfare is not the expert's primary ethical concern. Rather, their primary ethical duty is not to 'beneficence' or to 'non-maleficence' but to 'justice'. But notwithstanding the medical expert's primary or paramount duty being to the court, the medical expert is still bound by their duties as a doctor.

However, application of medical technique within assessment is highly likely to blur the asserted distinction between 'doctor' and 'forensicist' in the subject's mind, and even in the 'forensicist's' mind. So, the expert needs to be aware that, even if they have informed the subject that they are 'not being a doctor' in the ordinary way within the process of assessment, the subject may well not understand this, or continue to understand it beyond giving of the initial 'warning', even despite reiteration of the warning. Most obviously, doctors use their usual panoply of clinical skills and interaction in assessing a defendant, which must surely blur the distinction in the defendant's mind, also the doctor's.

Psychiatrists *may* refuse to give expert testimony (unless made subject to a witness summons) in cases where they believe that their testimony may 'do harm' to an individual. However, they should advise instructing solicitors or the court why they are doing so and be prepared to recommend alternative experts in the area or field, even if they know they share the same view.

Since there will always be some risk of negative outcomes for the person assessed, and since the degree of risk of a negative outcome will often be unpredictable, there is a duty on the expert to make it clear to the subject that:

- they can refuse evaluation or assessment
- the report is not confidential and might be seen by any number of professionals or legal bodies

- they do not have to answer all, or any, questions
- the expert is not there to provide them with treatment, but may produce recommendations for treatment in their report

Equally, the expert should advise the subject that, potentially anything discussed in the assessment may be referred to in the report; there is nothing 'off the record'. The expert cannot receive information 'in confidence'.

These are all points which can be included in the written consent form (see 'consent' section).

Accepting all of the foregoing, and despite the relationship being directed towards a legal purpose, the expert must remain aware and alert to their potentially overriding ethical duties as doctors (see ordinary clinical ethical duties section). Even if the purpose of the interaction between the expert and the subject is not directly therapeutic, some usual medical ethical duties are still operative, such as respect for autonomy (expressed by the obtaining of informed consent/refusal to evaluation and advising on the limitations of confidentiality); or the duty to alert another medical professional to a diagnosed medical condition where the person is not competent to refuse disclosure, and significant harm to the subject may result from non-disclosure.

Sentencing and medical recommendations

According to the Sentencing Act 2020, s57(2), the purposes of sentencing are punishment, reduction of crime, reform and rehabilitation, protection of the public and the making of reparation.

The hospital order with restrictions

In England and Wales, on conviction of an offence punishable with imprisonment, the court may make a hospital order under the Mental Health Act 1983 (amended 2007), s37, with or without restrictions under s41, if, having regard to all the circumstances, including the nature of the offence and the character and antecedents of the offender, it is considered to be the most appropriate disposal. In order to impose a s41 restriction order, it must be 'necessary for the protection of the public from serious harm', having regard to the nature of the offence, the antecedents of the offender and the risk of the offender committing further offences if set at large. A s37/s41 order is also possible in cases where a defendant is found not guilty by reason of insanity, or found unfit to plead but found to have done the acts or made the omissions charged.

The hybrid order

Under s45A, the court can also impose a hospital order with a limitation direction – a 'hybrid order' – according to which an offender goes to hospital but is then transferred to prison to serve the rest of the sentence once treatment in hospital is complete. Although the statutory criteria for a s45A are the same as for a s37, the outcome is very different, given that s 45A is ultimately punishment, unlike a s37 order (*R v Birch* [1989] 11 Cr App (S) 202). A penal sentence will also usually lead to supervision by the probation service on release rather than supervision under community mental health teams. Psychiatrists are often asked whether they would recommend a hospital order under s37 with or without restrictions but these same recommendations may be used by the court to make a s45A hybrid order.

The issue of culpability

The sentencing judge therefore has to balance the sometimes-competing purposes of sentencing. taking into account any medical recommendations. This has led to numerous legal challenges as to what the most appropriate sentence should be, the most notable being *R v Vowles* [2015] EWCA Crim 45 and *R v Edwards* [2018] EWCA Crim 595. According to *Vowles*, judges should consider the treatment for the mental disorder, its link with the offending, culpability requiring punishment and protection of the public. Although psychiatrists may reasonably comment on treatment, the link with offending, including the causal relevance of the defendant's mental disorder in determining commission of the index offence, and protection of the public, the role of expert psychiatric evidence in assisting the court to determine culpability is controversial.

Culpability is the degree to which a person can be held morally or legally responsible for their conduct. In *Edwards*, the court emphasised the need for the sentencing judge to determine culpability and asked the psychiatric experts to comment explicitly on the level of culpability themselves. This has been followed by a number of subsequent cases, including *R v PS* [2019] EWCA Crim 2286, where the court emphasised the need to determine an offender's culpability following the publication of a draft consultation document on 'sentencing offenders with mental health conditions or disorders' by the Sentencing Council in England and Wales in 2019. The final guideline 'Sentencing offenders with mental disorders, developmental disorders, or neurological impairments' has since come into effect. It helpfully substitutes for a 'precedent' approach the specified guideline, also requiring the judge to explain his sentencing of a defendant in its terms.

Although the sentencing of mentally disordered offenders has always been a difficult one for judges, the emphasis on the need for punishment in *Vowles* and the use of medical evidence in *Edwards* to determine culpability poses particular ethical difficulties for psychiatric experts (Hallett, 2019). There are many 'causal' factors relevant to culpability on which an expert may legitimately comment, such as an offender's psychiatric symptoms, capacity, insight, decision-making ability, use of illicit substances or help-seeking behaviour. Nevertheless, this is in a very different domain from then commenting upon the level of culpability, which should be resisted. There are other non-medical factors which are relevant to culpability, which is itself a concept 'outwith' psychiatry., It is for the court to determine the ultimate issue of culpability and subsequent need for punishment, not the expert. To do so is to step outside one's area of expertise.

A s45A hybrid order poses particular difficulty for an expert because the statutory criteria for admission to, and detention in, hospital for treatment under s45A are the same as for a s37. It is legally inconsistent for an expert to recommend a s45A hybrid order but not a s37 hospital order (*R v Hoppe* [2016] EWCA Crim 2258). Nevertheless, it is ethically problematic for experts explicitly to recommend a s45A hybrid order as it amounts to a recommendation of punishment which would not be so if the recommendation was limited to the recommendation for admission to and detention in hospital. As a s45A order is essentially 'supplementary' to a prison sentence, it is entirely different from a s37 hospital order. A s45A is no different, in essence and effect, from a transfer direction for a serving prisoner under s47. It is also distinct from a s38 interim hospital order, the purpose of which is to assess whether s37 would be appropriate. In practice, however, an expert only needs to recommend a hospital disposal under s37. They may point out, on the basis of their clinical judgement, the clinical and risk management advantages and disadvantages of a s45A hybrid order.

One advantage of a s37 order is that it can be accompanied by a s41 restriction order, which allows for more intensive long-term supervision by mental health services and the Ministry of Justice than would be the case if an offender were given a s45A order. An advantage of a s45A order, however, is that it allows the offender to be transferred to prison from hospital once their treatment is complete or if appropriate treatment is no longer available. This may be useful if the offender requires longer-term supervision by criminal justice agencies such as probation services. Nevertheless, it requires an offender's custodial sentence to exceed the time needed for their treatment in hospital in order for there to be the possibility of being transferred to prison. It is for the court to determine the most appropriate disposal on the basis of the particular facts of each case.

The interim hospital order

One of the difficulties with sentencing mentally disordered offenders is that the court often has to make a definitive decision about the best way of dealing with a case. In reality, however, the true extent and nature of an offender's mental disorder and the best way of managing their risks to the public may only become apparent with the passing of time. Experts should therefore consider making a recommendation for an interim hospital order under s38 if they think that further assessment in hospital will likely provide clarity about the most appropriate sentence.

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 the case 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.

Asking the right questions

Before making a recommendation for a hospital order, with or without restrictions, an expert should ask the following questions:

- Does this person fulfil criteria for a hospital recommendation due to the nature and/or degree of their disorder?
- How effective is treatment for their mental disorder likely to be?
- What is the link, if any, between their mental disorder and their offence?
- Will treating their mental disorder likely reduce their risks to the public in the longer term?
- If they were given a custodial sentence rather than a hospital disposal could their mental health be adequately treated in prison?
- If this person is given a hospital order under s37, is a s41 restriction order really necessary 'to protect the public from serious harm' given the significant restrictions and resources involved?
- Are the public likely to be better protected if this person were to be on a s37/s41 order or managed by the criminal justice system?
- Are there any clinical advantages or disadvantages of a s45A hybrid order over a s37 order?
- What medical factors might be relevant to the court's determination of their culpability?

Child protection and other safeguarding cases

There has been media criticism of experts in child protection cases, both paediatricians and child psychiatrists. Although not all of the criticism is well founded, there are real concerns about psychiatrists who, specifically in relation to child protection cases:

- give evidence beyond their expertise
- give testimony that is out of date, not properly evidenced or lacking in empirical knowledge base
- address questions that are the province of the judge or other fact-finding body
- provide biased testimony, through intrusion of personal values into the substance of their expert testimony
- fail to understand that in criminal cases involving young defendants, there may be other child welfare and protection issues that might give rise to additional legal actions under child protection legislation.

Psychiatrists giving evidence in the family courts need to be able to show that they have the necessary particular training and expertise in this complex field. Adult psychiatrists cannot assume that they can validly comment on parenting capacity, and child psychiatrists may not be able validly to comment on risk in adults.

There are now established requirements that experts in family cases will have appropriate knowledge; be active in the area of practice or have sufficient experience of the issues; have relevant qualifications; have received appropriate training, and be compliant with safeguarding requirements (Standards for Expert Witnesses in Children Proceedings in the Family Court (Lord Chief Justice (2014) (Annex to FPR 25BPD)).

In the family courts, the expert is often appointed as on a single joint basis, and the approach to evidence is more inquisitorial than adversarial. The single joint expert may also increasingly have to deal with litigants in person in court, especially in private law proceedings, and they will need to look to the judge in addressing questions that are complex or hostile.

A crucial area of difficulty in the family courts is the use of psychiatric evidence before fact finding has taken place. This is highly problematic as both psychiatric diagnoses and risk assessments rely on established facts, which are the substance of the court's fact-finding process. Further, prior to fact finding, few parents will feel able to be open and honest about their difficulties, and denial of mental health problems or risky behaviours is common. In *Assessment and management of adults and children in cases of fabricated or induced illness (FII)* (Royal College of Psychiatrists, 2020), the College sets out the consensus that it is good practice not to provide opinions before fact finding; but courts may press experts to do so because of the time constraints in family law proceedings involving child protection. In such a case, the expert is advised to adopt a formula along the lines "if the court finds X, Y and Z, it is my opinion ….and if the courts find A, B and C, it is my opinion that…."

Psychometric testing

Some psychiatrists include psychometric testing as part of their medicolegal assessments. Where such tests have been carried out, the expert should state the methodology used and, if appropriate, by whom the tests were administered and under whose supervision, summarising their qualifications and experience. In practice, this means that, where tests have been carried out by a psychologist who is not preparing a report in their own right, the psychiatrist has to identify the psychologist, state under whose supervision they carried out the tests (if they did) and summarise the psychologist's qualifications and experience. A psychiatrist cannot explain and defend tests which they are not themselves qualified to administer.

Often, which is almost always preferable, the psychologist will have been separately instructed by the lawyers in the case, usually on the advice of the medical expert, in which case the psychologist's report should be available to the court.

Experts have a duty to ensure that they obtain consent from the subject for the use of any instruments, which should be scientifically validated and evidenced as reliable. This is particularly the case in relation to risk assessment tools.

No expert should administer a psychometric tool for which they have not been properly trained and the expert should be able to provide evidence of training if requested by the courts. In practice, an expert who uses a published instrument or tool should be prepared to be cross-examined on its validity and reliability (particularly in relation to medicolegal settings) by a cross-examiner who is assisted by an expert who is qualified to administer the instrument and/or is familiar with the literature relating to that instrument.

Information governance and confidentiality

Confidentiality

An expert report, once completed, generally 'belongs' to those who gave instructions for it and not to the person assessed. In the criminal court, the defence, the prosecution or the court will 'own' the report. In the family court, where a single joint expert has been appointed, the report belongs to the court. However, in private law family proceedings and where the report has been obtained by a LIP (p26), the subject of the report may 'own' the report. In any event, the *information* within the report does still 'belong' to the person assessed, and experts should strive to respect the normal duties of confidentiality. This should include proper procedures for the secure storage of documents and records, and the use of passwords and/or encryption to ensure the security of electronic files. The duty of respect for the process of justice determines that experts should retain all their notes that do not form part of the litigation bundle and which are personal to them. They should destroy all other information with which they may have been provided once the case has been completed.

Retention periods

Although the period required for this varies according to the nature of the case, for example ranging in criminal cases from one to, for serious cases, 20 years, according to the Information Governance Alliance (2016) records management code of practice for health and social care, records of medicolegal assessments would fall into the basic health and social care retention period of 8 years. It is worth noting that the subject of a medicolegal assessment has 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 experts give appropriate instructions about retention of records to their executors.

Disclosure

Reports should not be disclosed without the assessed person's consent and/or consent of their legal representatives, or unless directed by a court, other than in exceptional circumstances (see below). In many family cases, only the court can consent to the disclosure of the expert's report. Where it is in the assessed person's interests, or where there are concerns about risk of imminent serious harm, it is justifiable to seek permission to disclose the contents of the report. However, experts are under a general duty of confidentiality not to disclose the content of their reports and they may need explicit permission from the courts to disclose any material to any other party. If disclosure is sought by a third party, it is advisable, in any event, to seek the view of the instructing solicitors or court.

The apparent consent of children should be assessed by a suitably qualified professional. Capacity issues and specific caveats apply to those aged 16 and 17 years whose decision-making processes might still be affected by developmental immaturity. For those under 16, issues of Gillick competence will need to be addressed. Parental consent might also need to be considered.

Only in exceptional circumstances relating to the prevention of violence or harm to others, where there is an imminent significant risk of serious harm or where there is a duty to intervene immediately using statutory powers, should material from an expert report be disclosed to any third parties without consent or discussion with legal parties. Experts should expect to defend this decision legally and professionally. Specifically, there is a right to breach confidence where there is a 'significant risk of serious harm to others' in the absence of such breach (see *W v Egdell*, [1990] 1 All ER 835).

In all cases and legal settings, it is important to maintain respect for confidentiality, honesty and impartiality. The risk of breach of this may be greater in cases that have a high media profile.

The General Data Protection Regulation

All experts who receive or store information in connection with medicolegal work are data controllers under the General Data Protection Regulations (GDPR). As such, they must conform with associated legislation. As data controllers they must have undertaken a data audit and have available the following written policies: data subject request policy; data breach policy; data protection policy, and security policy. They should provide a privacy notice to subjects whose data they process. They must be registered with the Information Commissioner's office (ICO). They should take all reasonable steps to ensure that information they hold is secure, including physical, organisational and technical measures to ensure a level of security appropriate to the risk.

For information held electronically this should include, but is not limited to, encrypted and password protected computers, antispyware and antivirus software installations, encryption of personal data before it is uploaded to the cloud and use of encrypted email or password protected attachments. Experts should be aware of their responsibility to inform the ICO should there be a data breach. It is advisable to have indemnification against losses caused as a result of a data breach, including losses incurred by an instructing party.

The recording of assessments

Occasionally, individuals undergoing assessment by a medicolegal expert seek to record the examination either overtly or covertly. With the ready availability of audio and video recording devices, this is likely to increase. It is not a criminal offence to record a medical examination covertly and experts should be mindful of the possibility of being recorded without their knowledge. If permission is requested to undertake a recording, the expert should obtain assurance that the recording will not be disclosed to anyone other than the subject of the report and their legal representatives; will only be used in the context of the legal proceedings, and will be destroyed once legal proceedings

are completed. The expert should also liaise with their instructing party. It would be prudent for the expert to make a recording simultaneously to be kept securely by them with an agreement that the recording can also be made available to their instructing party, should that be necessary. Obtaining such assurance and agreement in writing is preferable.

Consideration should be given as to whether a recorded assessment and mental state examination may influence the assessment and should be commented upon accordingly in the report. Being recorded inevitably alters the dynamic of an assessment and could give misleading information regarding the subject's mental state. The subject may be overly constrained or unforthcoming or they may be over-emotional, disinhibited and expressive, all through knowing that whatever they say – and how they say it – will be recorded. The psychiatrist may also feel overly constrained, which would interfere with how the interview is conducted.

A psychiatric assessment by its very nature explores potentially sensitive areas including personal history, evidence of abuse or trauma, relationship history, sexual history, religious beliefs etc. There may be reluctance by the subject to have this part of the interview recorded, particularly if they did not anticipate such exploration. An experienced psychiatrist will gauge how to support the subject and allow time and space for them to compose themselves after making distressing revelations or describing traumatic memories. Having this distress recorded so the subject can play it back may re-traumatise the subject in an uncontrolled environment.

A recording is evidence that can be disclosed to the court. It must be retained for the same length of time as paper or electronic records.

Remote video assessments by experts have become much more common during the Covid-19 pandemic and experts have had to decide as to whether a scheduled face-to-face assessment should be replaced by a remote interview by video, or whether video assessment would be too unsatisfactory and not in the interests of justice. When coming to a decision, it is necessary to prepare for the decision to be challenged. There is a balance to be struck between undertaking an assessment in less-than-ideal conditions but allowing the court process to progress and not being able to fulfil the expert's duty to the court because the assessment is inadequate in the circumstances.

If a video assessment is preferred, it is incumbent upon the expert to ensure that a secure platform is used in order to maintain confidentiality. As is the case for recorded assessments, it is important to comment in the report as to whether a remote interview may have affected the assessment by interfering with the accurate determination of aspects of the mental state examination such as body language, demeanour, affect, prosody, distractibility and mood. Connection difficulties could affect the ability to establish rapport and control the interview, there may be interruptions and third parties may be present (possibly out of view).

Complaints and professional regulation

Complaints to or about the expert

Even experts whose reports constitute objective, unbiased and independent evidence to assist courts and tribunals may, sooner or later, be the subject of a complaint from a litigant who disagrees with their opinion because the report is not supportive, or sufficiently supportive, of their case as they see it. Some will have mistakenly believed that their solicitors were employing 'a hired gun' or may complain about the behaviour of an expert instructed by the other side within clinico-legal interviews (see the 'Testing the Evidence' section). With the early and prompt involvement of the instructing solicitors, it will often be possible to head off such complaints. However, some litigants will not give up and may make a complaint to the GMC. Some may see the expert as intrinsically hostile simply because they have been instructed by the other side.

Experts need access to a complaints procedure and this might include an offer to ask a colleague, perhaps a peer group member, to give an independent opinion. However, that may not satisfy a litigant who suspects that the complaint will be adjudicated by an expert who will simply close ranks. Experts who are members of the Academy of Experts or the Expert Witness Institute can direct the litigant to one of these bodies, as they have procedures for handling complaints against their members. Every effort should be made to resolve the complaint before the GMC becomes involved, as protracted inquiries at the investigatory stage can be distressing, and all the more so if the case is referred to the MPTS for adjudication. In any event, the complaints should be referred to the expert's MDO and discussed in the peer group.

Complaints are usually made after a case has concluded and in response to the outcome. A complaint made when a case is ongoing, particularly if it is accompanied by a threat of referral of the expert to the GMC, immediately runs the risk of being perceived as amounting to 'pressure' being placed upon the expert; indeed, it almost certainly must amount to pressure. And this must result in the expert having to withdraw from the case, since to continue must leave them at risk of exhibiting 'bias' in the opinion they form. Such a complaint made by a litigant, through their solicitor to the instructing solicitor, also amounts, *de facto*, to interference with the justice process if it amounts to a 'threat'. Complaint separately to the GMC, in the absence of making the complaint 'within the litigation', would not so obviously amount to a threat, especially if the complaint were to be made after completion of the litigation.

Complaining about another expert

Circumstances sometimes arise in which an expert is minded to complain about another expert. What to do about it, and when, will depend on the nature of the perceived wrong-doing and the stage of the litigation. Few experts, *if any*, can look back over their years of expert witness practice and say that they have never made a mistake. Experts

should, and almost all do, learn from their mistakes. Any action taken against another expert should therefore be conciliatory, constructive and respectful. Usually concerns about the behaviour of an expert arise during litigation, including at a pre-trial stage and often following an experts' meeting. Any significant concerns should be drawn to the attention of the instructing solicitors, but it is important not to initiate any formal complaint against the expert while the case is ongoing, as this can unnecessarily complicate the litigation. Instructing solicitors and/or counsel will decide what, if anything, should be done while the litigation is ongoing.

When the case is concluded, unless the instructing solicitors or counsel wish to do otherwise, the complaint should be put directly and informally to the expert; and they should be advised to consider discussing it with their peer group, and including the views of their peer group in their response. Where mistakes result from inexperience, misunderstanding or simple ignorance which the expert recognises, and about which they agree to seek further training or simply change the way that they behave, and which they undertake to disclose at their annual appraisal, no more action may be necessary. In exceptional cases, where the expert refuses to accept that they have done wrong, and sometimes where they are known to have behaved similarly in other cases, further action may be necessary.

Policing the specialty

Unscrupulous, careless and unethical experts hinder the administration of justice and damage the reputation of the profession. Experts who engage with them in litigation are probably best able to expose and delineate their shortcomings and misdemeanours., They do a disservice to their profession if they turn a blind eye and do nothing about the erring expert.

The GMC states in Good Medical Practice: 'If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us'. Arguably this must also be the advice in a case where there is concern that a psychiatrist may not be fit to practise as an expert psychiatric witness and may be putting the administration of justice at risk, particularly given that referral to the GMC can be based upon clinico-legal failure.

But any action taken beyond an informal approach to the expert should be taken with the utmost care, and having regard to independent advice. Such advice should be sought from the expert's own peer group and from the College's regional advisor. In order to try and avoid the matter escalating to the level of a GMC investigation, it may be appropriate for the complaint then to be brought to the attention of the expert's 'responsible officer'. It is also advisable for the expert who is initiating the complaint to inform their own MDO, and act on any advice they offer. The erring expert is likely sooner or later to seek the advice of their own medical defence organisation. In a contentious case that does proceed as far as a GMC investigation or MPTS proceedings, the expert who has initiated the complaint needs to be able to demonstrate that they have acted in a wholly professional manner.

Some salutary cases

The very few cases of psychiatrists whose 'fitness to practise' has been found to be impaired by the GMC, or now the MPTS, as a result of their practice as an expert witness, helpfully give an indication of the nature and degree of the failings which may be judged to amount to such unfitness.

In one case, a consultant psychiatrist, whose peers regarded him as clinically competent, had significant experience of family cases and was well regarded as an expert in this area. However, he had little experience of criminal proceedings and prepared a report in a criminal case where diminished responsibility was at issue. At the trial, he was seen to demonstrate deficiencies in his expertise, experience and preparation in regard to diagnosis of intermittent explosive disorder (IED); obligations for disclosure; and understanding of the legal framework for diminished responsibility. At the conclusion of the trial, the judge referred him to the GMC with a view to his undertaking training on the role of an expert in criminal trials. However, he then faced fitness to practise proceedings and was found to have been reckless in his expression of the opinion that the defendant suffered from IED; in not explaining that this diagnosis was controversial; and in persisting in his diagnosis of IED even after his diagnosis had been challenged by the Crown at trial. Further, he was found to have been reckless in not mentioning that he had not read the witness statements and in not making clear the provisional nature of his report. The Panel found misconduct and, for that reason, his fitness to practise was found to be impaired. The Panel determined to suspend his registration for four months.

In the case of a psychiatrist who prepared a psychiatric report on a paramedic for fitness to practise proceedings, a fitness to practise panel of the MPTS found that in his report, he failed adequately to explain the basis of his opinion; he failed to restrict his opinion to areas in which he had expert knowledge or direct experience and to matters that fell within the limits of his professional competence; and he failed to state where a particular question fell outside his area of expertise. The panel also found that, at a preliminary hearing, he had displayed an inadequate understanding of the role and responsibilities of an expert witness; and he failed to admit that he did not have appropriate expertise in the field of adult psychiatry. The panel went on to find that such failures were sufficiently serious as to amount to misconduct, so it suspended his registration for 3 months. On appeal, the finding of misconduct was upheld, although for the sanction of suspension was substituted a direction that, for 3 months, he should be subject to a condition on his registration that he should not accept instructions to act as an expert witness in fitness to practise proceedings.

In an MPTS case where a consultant psychiatrist prepared an independent psychiatric report for care proceedings and subsequently prepared a report for mental health tribunal proceedings, the expert admitted a number of allegations including that he had:

- concluded that the subject's partner was "completely normal and responsible" without having conducted a psychiatric assessment in respect of him
- failed to assess whether the subject had the capacity to instruct him regarding her transfer, provide informed consent to be transferred to another hospital, and pay for his services
- failed to seek an opinion as to whether she had capacity in respect of these matters
- inappropriately requested monies from her before liaising with her responsible

clinician or a nominated medical deputy
- undertaken a psychiatric assessment of her in advance of a Mental Health Tribunal hearing and failed to document his assessment.
- given oral evidence to a Mental Health Tribunal at which he contradicted statements contained within his report
- not provided a clear opinion as to whether or not she had a mental disorder.

The Tribunal made findings as to the allegations which were denied. It found that:

- the expert had an obligation to take an adequate medical history from the patient herself, which ought to have included her past psychiatric history, past medical history, past psychiatric medication, forensic history, social history and substance misuse history, but failed to do so
- the content of the expert's report did not reflect that an adequate and appropriate mental state examination had been undertaken detailing her appearance, behaviour, mood, speech, thought form, thought content, perceptual disturbance and insight
- the expert failed to give adequate consideration to the opinions of other treating clinicians
- the expert's report did not cover in a logical or sequential way what previous contact the patient had had with mental health professionals, what medication she had previously been prescribed, what therapeutic interventions she had been offered and any previous inpatient admissions
- in concluding that the patient's partner was "completely normal and responsible" without having conducted a psychiatric assessment in respect of him, the expert was dishonest
- before agreeing to act on her behalf to effect her transfer from an NHS hospital to a private hospital, the expert failed adequately to consider the patient's vulnerability to financial exploitation at times of illness
- the expert failed to advise the patient of her right to ask her nearest relative to request her discharge from hospital
- the expert emailed the patient and inappropriately requested monies from her before liaising with her husband
- instructed by the patient's solicitor to prepare an independent report for the purpose of Mental Health Tribunal proceedings, inappropriately, when the patient was clearly a vulnerable patient who was detained under the Mental Health Act, the expert charged a fee (which included an amount to be paid by the patient herself), without first ensuring that she had capacity to agree to such fees.

The Tribunal was satisfied that the expert's reports fell well below the standards expected of a reasonably competent psychiatrist and consequently amounted to misconduct. It further noted that, following the First Tier Tribunal, the expert telephoned a Tribunal member at home and out of hours. It held that as an experienced medicolegal expert, he should have and would have known that contacting any member of the First Tier Tribunal was at best inappropriate and that any post-hearing communication between members and witnesses would be a potential cause for appeal; would place the member contacted and the Tribunal as a whole, in a difficult position. In relation to this and the expert's dealings with others in relation to the patient's case, it was the Tribunal's opinion that his conduct fell seriously below the standard expected of a reasonable competent psychiatrist and amounted to misconduct. The Tribunal found that, by stating his report prepared for Family Court proceedings that he had examined the patient's

partner and found him to be ‘completely normal without signs of history of psychiatric problems’ without having conducted a psychiatric assessment in respect of him, his conduct was dishonest. The Tribunal was satisfied that his dishonesty fell seriously below the standard expected of a reasonably competent psychiatrist and amounted to misconduct. The Tribunal therefore determined that the expert’s registration should be suspended for a period of 6 months.

The reluctant expert

Psychiatrists concerned about potentially having a negative effect on litigants (concerned that thereby they are contravening the requirement 'first do no harm') must be mindful of the fact that, although they may choose to withdraw from particular classes of expert witness work, this may skew the range of expert opinions which would otherwise be available to the court.

The Family Justice Council's (2020) *Working Group on Medical Experts Final Report* came about as a result of a "paucity of medical expert witnesses in family cases involving children" and one of the shortage groups identified was "child and family psychiatrists". Lawyers who were surveyed had noted a decline in the quality of expert reports. A decline in quality of reports by child/child and family psychologists topped the list and was reported by 33.7%. Next came paediatricians with a decline noted by 26.3%, then child/child and family psychiatrists 22.2% and adult psychiatrists 18.9%. Although it is entirely possible that psychiatrists were producing lower quality reports, the more likely explanation for this finding is that the psychiatrists who had been producing high-quality reports were no longer accepting instructions and psychiatrists capable of assisting the courts with high-quality expert psychiatric evidence are not taking up expert witness roles.

The College itself is sometimes contacted when courts require expert testimony on specific issues such as the viewing of images depicting suicide, the effects of social media on mental state or the effects of social media that promote self-image issues associated with eating disorders, alcohol and substance misuse, deliberate self-harm, bullying and sexual risk behaviours. Such requests not only raise usual issues such as the need to restrict evidence to the expert's field of expertise, but also issues such as extrapolation from clinical knowledge to novel situations and reliance on limited and poor-quality research literature and professional guidance which may result from professional consensus rather than robust research evidence. It is understandable that members who have knowledge and experience of such matters should be wary of offering assistance. However, it is better for the courts to be assisted by qualified, even heavily qualified, opinions and to understand the limitations, inadequacies and weaknesses of research and guidance than to have no assistance at all.

What a medical ethicist wrote in 1803 is as applicable today:

> "It is a complaint made by coroners, magistrates and judges, that medical gentlemen are often reluctant in the performance of the offices, required from them as citizens qualified by professional knowledge, to aid the execution of public justice."
>
> – Percival (1803)

The administration of justice depends on the willingness of psychiatrists to play their part by offering expert assistance as and when required. The guidance in this report is intended to ensure that psychiatrists who provide expert evidence to courts and tribunals adhere to the highest professional and ethical standards in fulfilling this important public office.

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