"Questions that can never be solved ?" (B v Nugent Care Society) The challenges for the skilled witness in claims relating to historical reports of abuse in childhood.

Professor Craig White

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Compass Chambers Annual Conference, Edinburgh, 17th November 2023

The content of this presentation has been specifically prepared to contribute to an educational event. It is based on my personal reflections, in general terms, of work as a skilled/expert witness in proceedings relating to claims of psychological injuries resulting from abuse experienced in childhood.

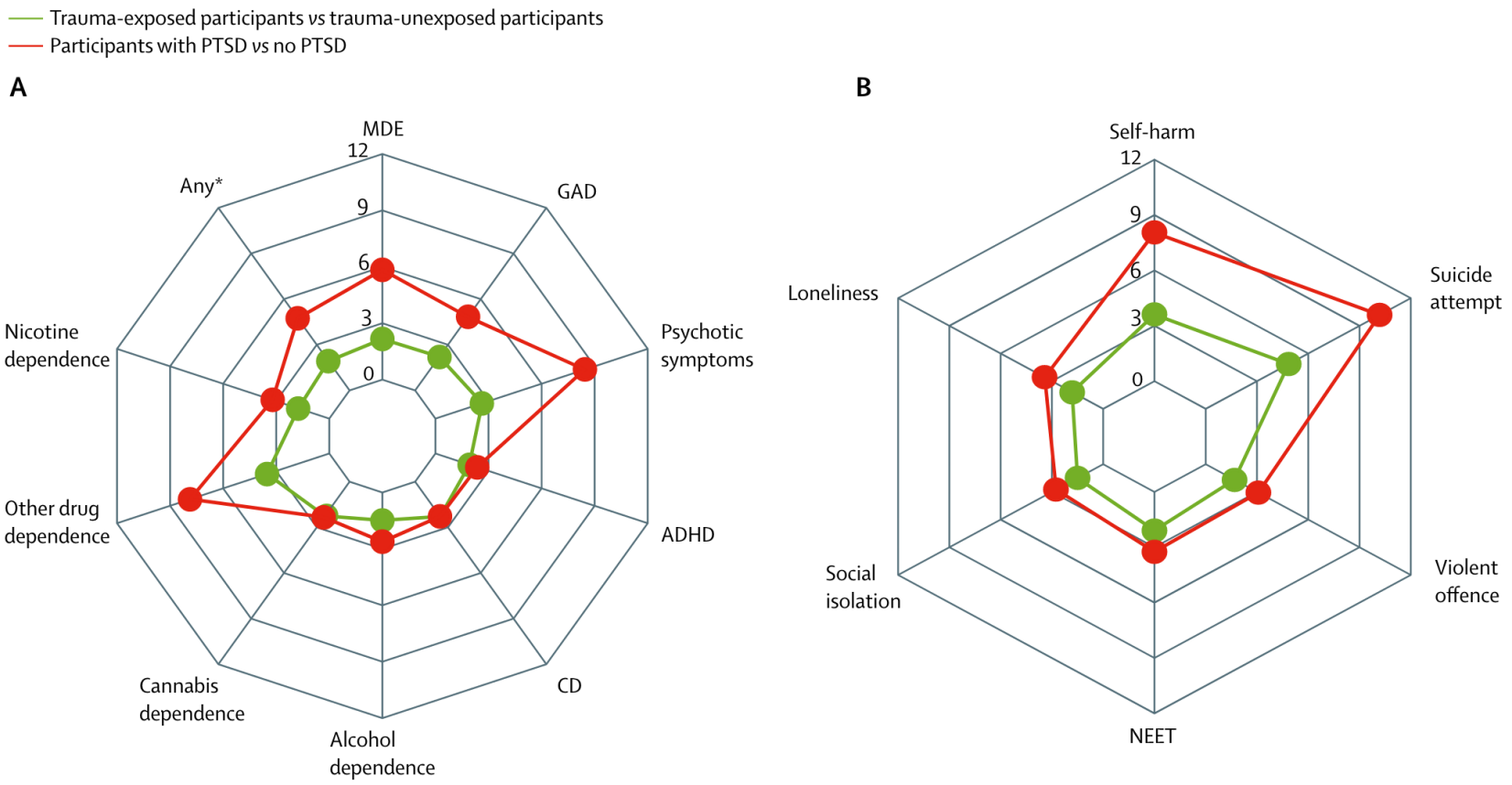
The content and empirical papers referred to are included as prompts for participants to consider and to emphasise some of the specific issues considered in general when undertaking this work.

No reliance should be placed on the relevance and applicability to any opinions offered historically or in the future for specific cases where I have been or may be instructed, or in any other professional activities.

This work has been carried out independently of my role in the public sector which is subject to separate governance and accountability processes to that governing my independent consultancy work.

Overview

- What are the challenges for the skilled witness ?
  - Diagnosis
    - Which system – ICD-11 or DSM 5 TR
    - Specific considerations in respect of mental disorder
    - How is competence determined ?
  - Process considerations
  - Available Information
    - The background documentation – reliability and reliance on
    - Delays and iterative disclosure – is there a clinically plausible explanation ?
    - Access to and retrieval of memories
- How to approach the questions in search of 'solutions'
  - Recognise both the utility and the significant weaknesses of diagnosis
  - Respect the legal tradition, custom and practice and expectation <u>BUT</u>
  - Use a broad range of information and consider the limitations of it all
  - Pathognomonic processes can be helpful in determining causation and contribution
  - Concepts of mechanism of injury and divisibility are perhaps more reevant than traditionally recognised



Lewis, S.J., Arseneault, L., Caspi, A., Fisher, H.L., Matthews, T., Moffitt, T.E., Odgers, C.L., Stahl, D., Teng, J.Y. and Danese, A., 2019. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. The Lancet Psychiatry, 6(3), pp.247-256

Clarity, consistency and working definitions of terminology are problematic

Psychiatric damage

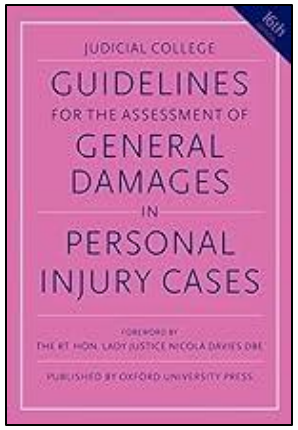
Psychological damage

Psychological injury

Reactive psychiatric disorder

Psychological reaction

Psychological effects



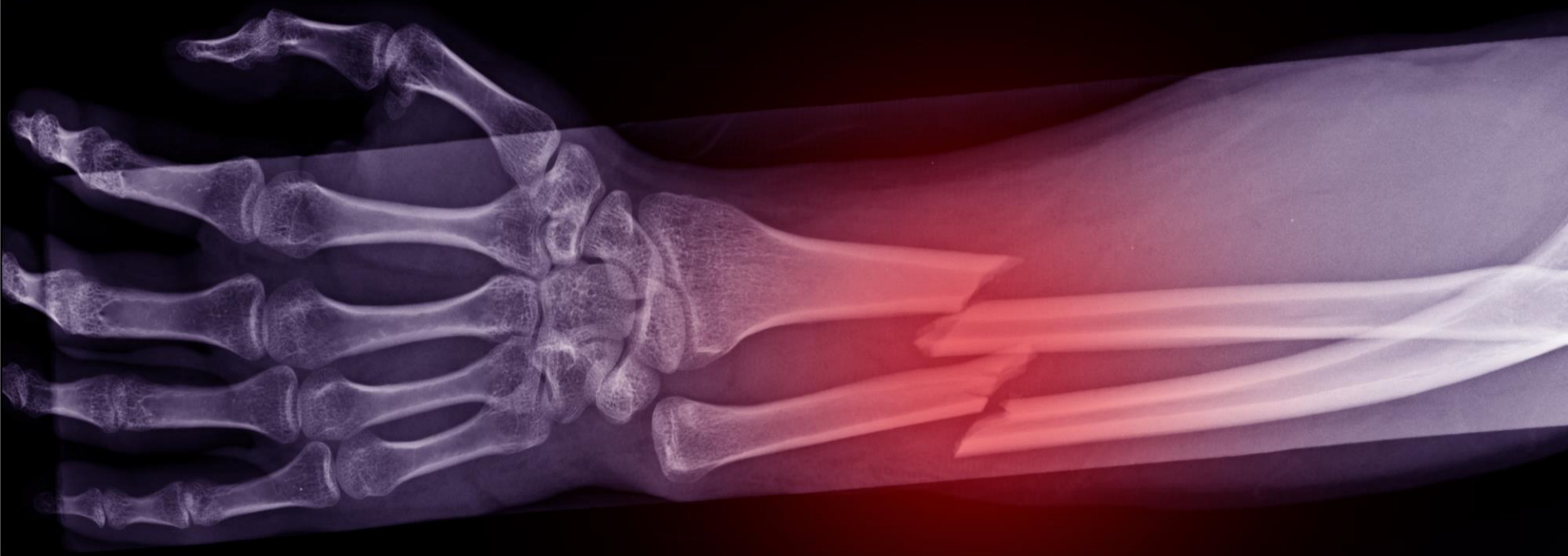
- Diagnostic classification
- Categorial or dimensional
- Genetic or environmental
- Documented in historical records or not
- Self reported or prompted by screening question
- Prompted by question on questionnaire or asked verbally

Not merely grief, distress or any other normal emotion

(*McLoughlin v O'Brian* [1983] 1 A.C. 410.)

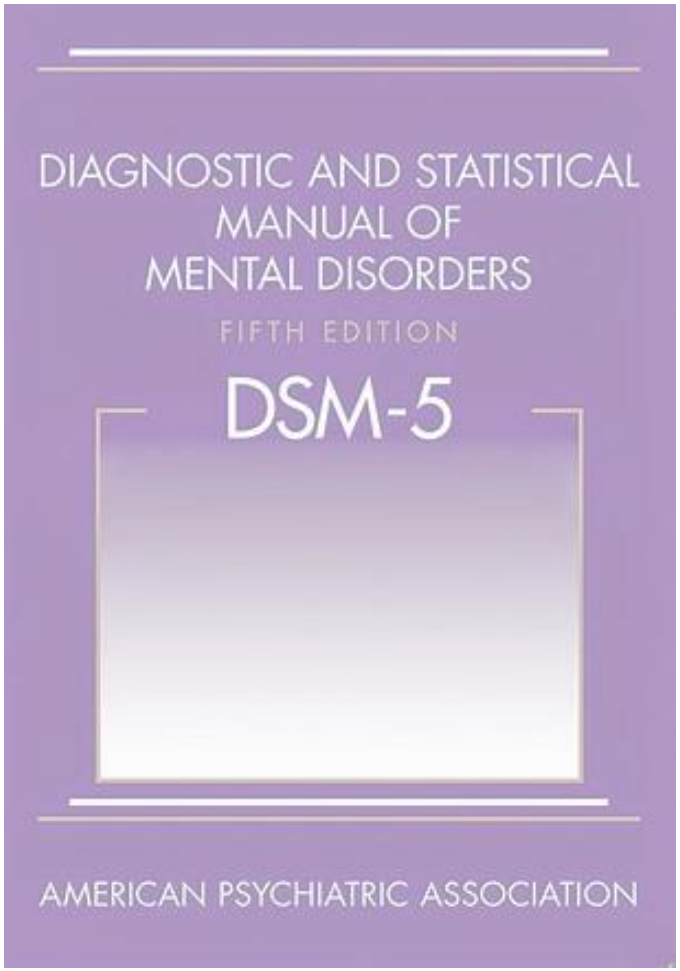
"There is no blood to be seen, no fracture to be examined"

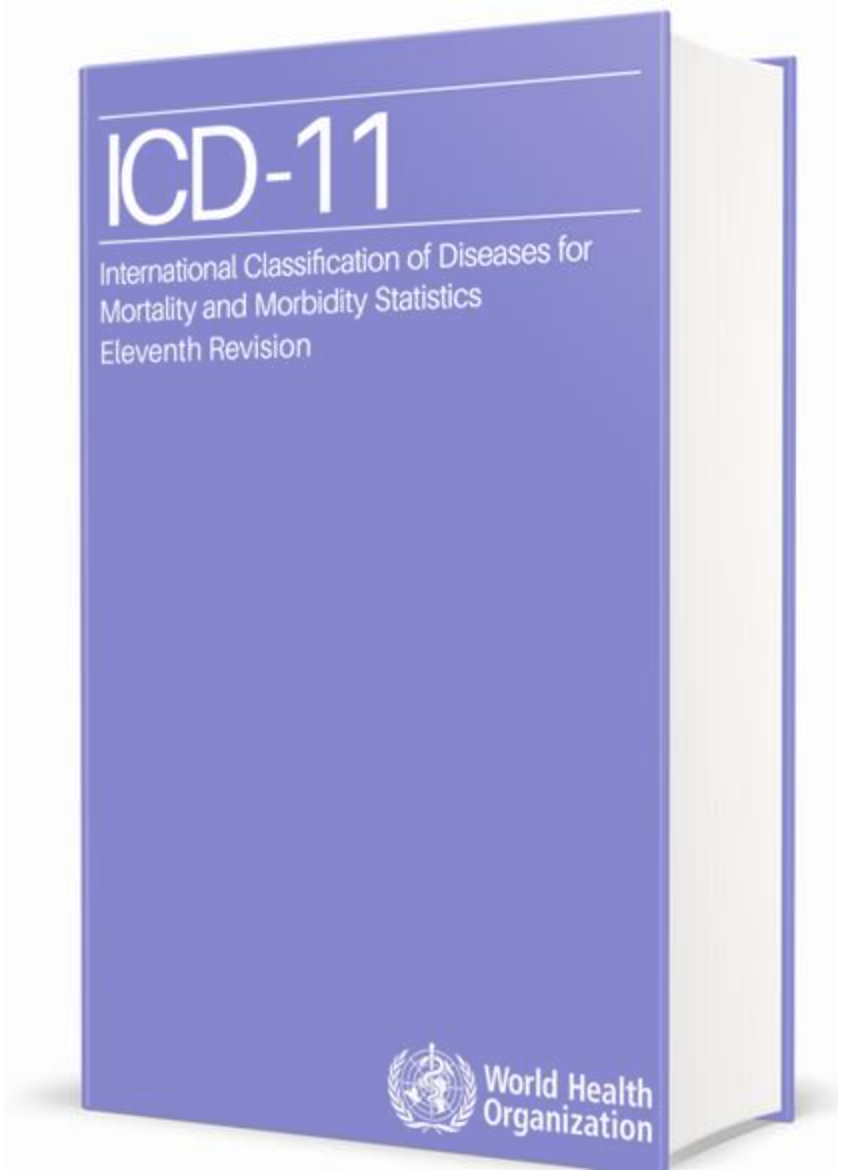
Turner v Jordan, 2010 WL 2595041 (2010)



A consequence of the fact that diagnosis in a psychiatric case depends upon 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.

Turner v Jordan, 2010 WL 2595041 (2010)





"Those bloody books"

(*The Government of the United States of America v Julian Paul Assange [2021] EW Misc 1*)

It was submitted on his behalf that he was qualified to diagnose mental illness, and that his training as a psychologist enabled him to do so. The Court of Appeal did not agree "No doubt his training gave him some insight into the medical science of psychiatry. However, not being a medical man, he had of course no experience of direct personal diagnosis. He was not qualified to act as a psychiatrist. Mr Irving's evidence was not medical evidence and was not admissable"

Brahams, D., 1983. R v Mackenny and Pinfold. *Medico-Legal Journal*, 51(2), pp.100-106.

Dr Cochrane stated that these symptoms met the criteria for Post-Traumatic Stress Disorder. This was accordingly not a diagnosis, but an observation by Dr Cochrane that the symptoms described met the criteria. In any event, Dr Cochrane was of course not a psychiatrist or indeed a medical practitioner.

D v D, [2021] CSOH 66

This is not a case where a psychologist is being asked to provide an opinion outwith the bounds of their professional discipline, such as a psychiatric opinion (R v MacKenny 1983 76 Cr App Rep 271 at 275).

HMA v KB [2022] HCJ 1 IND2018-2693

In our judgment, however, although the learned judge did not approach the matter in this way in his ruling, admissibility could have been better analysed and justified on the grounds that it provided evidence of psychological injury in exactly the same way as any doctor might give evidence of physical injury consistent with a particular allegation.

Regina v Adam Eden [2011] EWCA Crim 1690, 2011 WL 2582677

World Health Organization

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders

Note: This document is a pre-publication version of the ICD-11 Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders. This document will be proofread for typographical errors and consistency with WHO style; edits will be made accordingly. The document will also be formatted for printing prior to its publication.

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Intended Users of the CDDR

The CDDR are designed to be used by mental health professionals who are authorized by training, scope of practice, and applicable statute to provide diagnostic evaluations of people with mental disorders (e.g., psychiatrists, psychologists in some countries). It is also intended to be useful to non-specialist health professionals (e.g., primary care physicians, nurses), who in many countries provide a substantial proportion of total mental health

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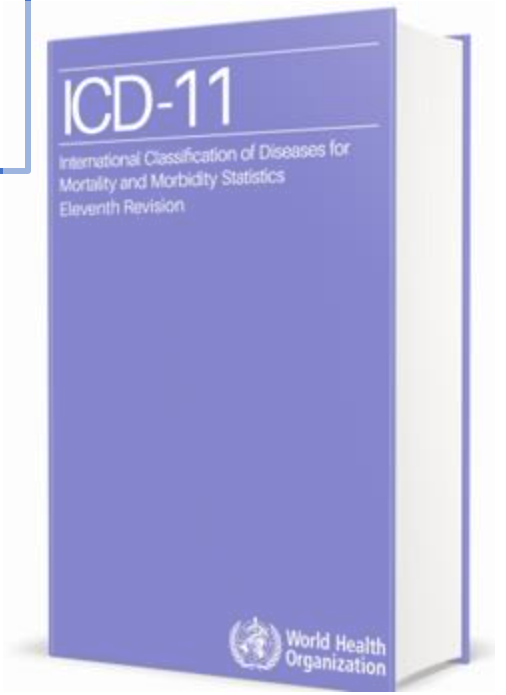
Not merely grief, distress or any other normal emotion

(McLoughlin v O'Brian [1983] 1 A.C. 410.)

Boundary with Normality (Threshold)

This section provides guidance regarding the differentiation of the disorder from normal variation in characteristics that may be continuous with, or similar to, the Essential Features of the disorder. This section often specifies aspects of the disorder that are indicative of its pathological nature and describes typical false positives (i.e., clinical presentations that are similar in certain respects but are considered to be non-pathological). For many disorders, the differentiation from normality is based on the presence of significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.



This acknowledges that

Craig White

has successfully completed the following unit:

Unit 4: Mood Disorders

of the Training Course on ICD-11 Guidelines for Mental, Behavioural, and Neurodevelopmental Disorders

on 02-04-2023

Geoffrey M. Reed, PhD
Professor of Medical Psychology
(in Psychiatry)

Kathleen M. Pike. PhD
Professor, Departments of Psychiatry and Epidemiology

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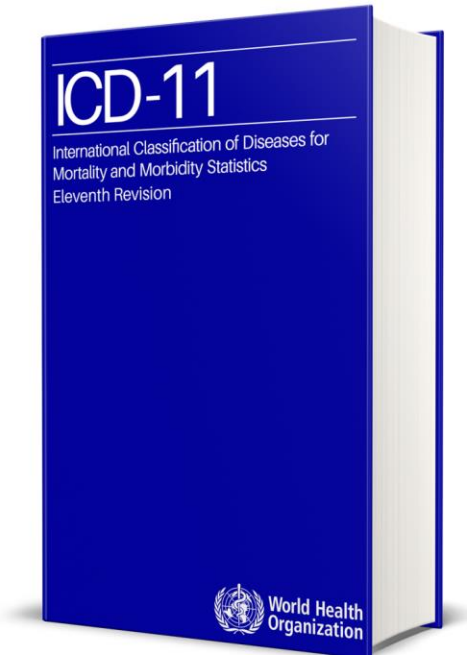


Problems with "algorithmic pseudoprecision"

Tyrer, P. ed., 2023. Making Sense of the ICD-11: For Mental Health Professionals. Cambridge University Press.

Both prevailing diagnostic systems operate with the idea that a PTSD diagnosis is either present or absent based on a specific array of symptoms, and individuals with PTSD maintain or lose their diagnosis with time.

PTSD criteria in DSM-IV, DSM-5, ICD-10, and ICD-11

	Symptoms required
DSM-IV criteria	
A1. Exposure to actual or threatened death, serious injury, or a threat to physical integrity of oneself or others	
A2. Response to the event involved fear, helplessness, or horror	
B. Persistent re-experiencing	One of five
C. Persistent avoidance and numbing	Three of seven
D. Persistent hyperarousal	Two of five
E. Duration of at least 1 month	
F. Clinically significant distress/impairment	
DSM-5 criteria	
A. Exposure to actual or threatened death, serious injury, or sexual violence	
B. Persistent re-experiencing	One of five
C. Persistent avoidance	One of two
D. Persistent numbing	Two of four
E. Persistent hyperarousal	Two of five
F. Duration of at least 1 month	
G. Clinically significant distress/impairment	
ICD-10 criteria	
A. Exposure to a stressful event or situation of exceptionally threatening or catastrophic nature likely to cause pervasive distress in almost anyone	
B. Persistent re-experiencing	
C. Avoidance	
D. Either (1) or (2) below:	
1. Inability to recall important aspects of the stressor	
2. Persistent hyperarousal	Two of five
E. Criteria B, C, and D must all be met within 6 months of the stressful event	
ICD-11 criteria	
A. Exposure to a stressful event or situation of exceptionally threatening or horrific nature likely to cause pervasive distress in almost anyone	
B. Persistent re-experiencing that involves not only remembering the TE, but also experiencing it as occurring again	
C. Avoidance	
D. Persistent hyperarousal (i.e., heightened perception of current threat)	
E. Clinically significant functional impairment	

Fischer, I.C., Pietrzak, R.H., Maercker, A., Shalev, A.Y., Katz, I.R. and Harpaz-Rotem, I., 2023. Post-traumatic stress disorder: rethinking diagnosis. The Lancet Psychiatry, 10(10), pp.741-742.

Stein, D.J., McLaughlin, K.A., Koenen, K.C., Atwoli, L., Friedman, M.J., Hill, E.D., Maercker, A., Petukhova, M., Shahly, V., Van Ommeren, M. and Alonso, J., 2014. DSM-5 and ICD-11 definitions of posttraumatic stress disorder: Investigating "narrow" and "broad" approaches. Depression and anxiety, 31(6), pp.494-505.

COMORBIDITY WITH LIFETIME PTSD

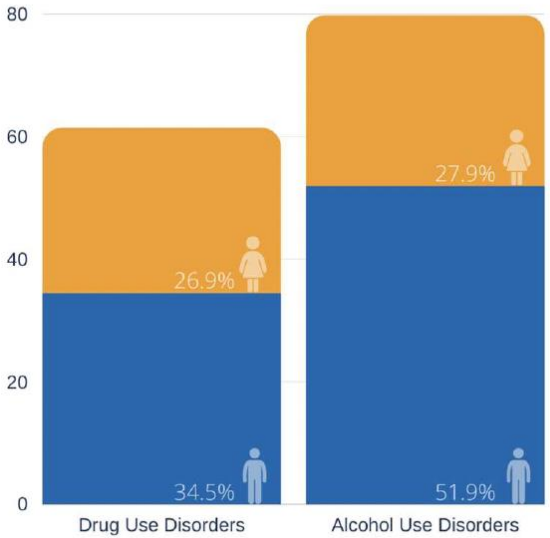
SUD Lifetime Prevalence

40%
Individuals with PTSD

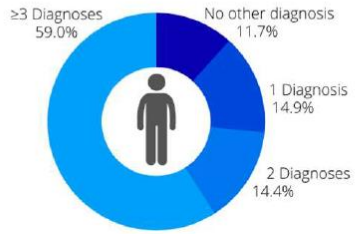
PTSD Lifetime Prevalence

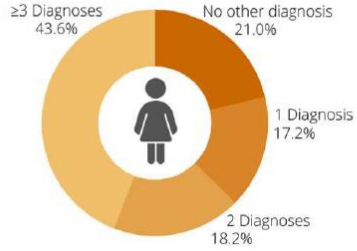
14%-60%
Individuals with SUDs

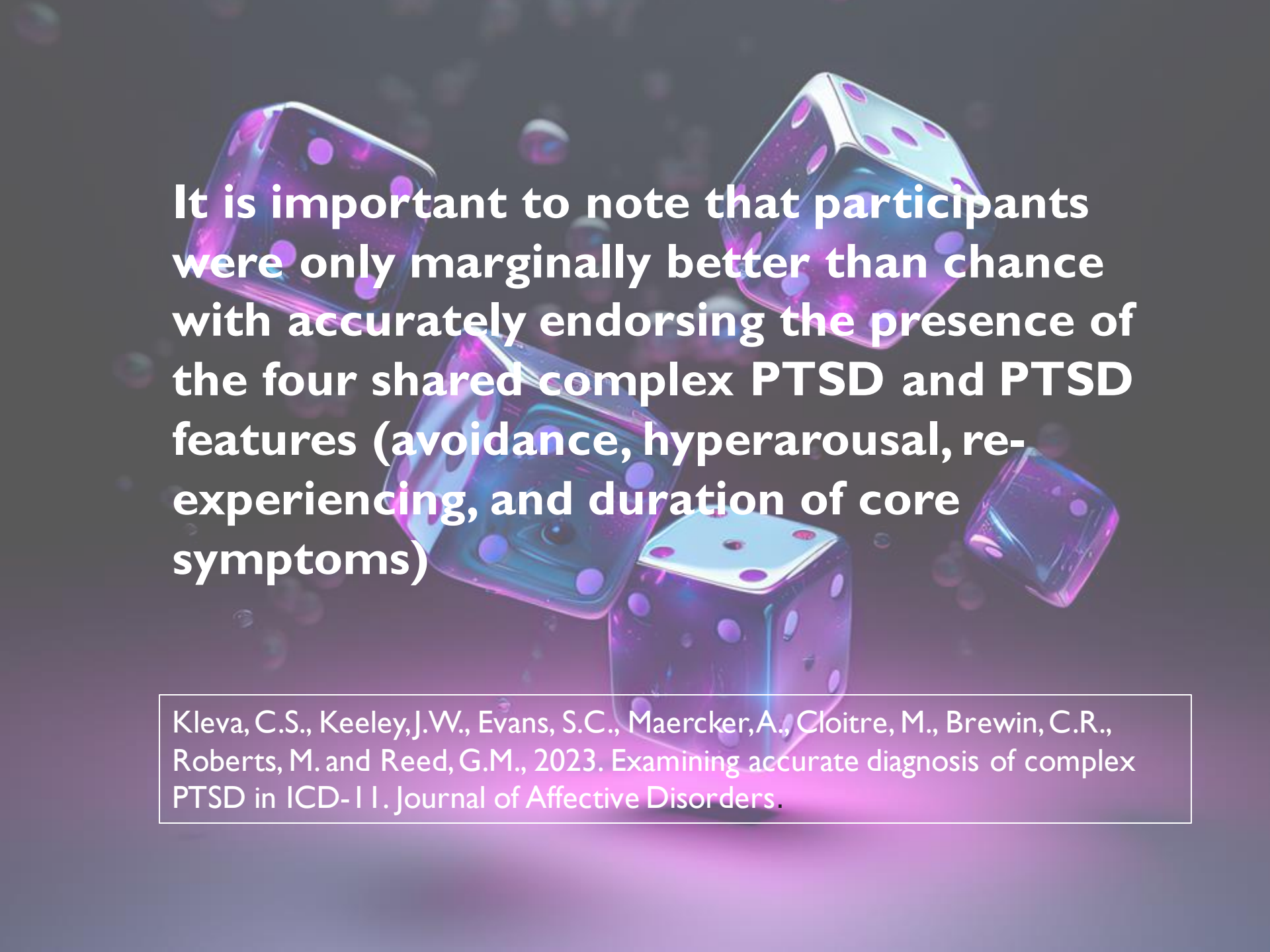
Substance Use Disorders



Any Disorder







It is important to note that participants were only marginally better than chance with accurately endorsing the presence of the four shared complex PTSD and PTSD features (avoidance, hyperarousal, re-experiencing, and duration of core symptoms)

Kleva, C.S., Keeley, J.W., Evans, S.C., Maercker, A., Cloitre, M., Brewin, C.R., Roberts, M. and Reed, G.M., 2023. Examining accurate diagnosis of complex PTSD in ICD-11. Journal of Affective Disorders.

Diagnostic Requirements

Essential (Required) Features:

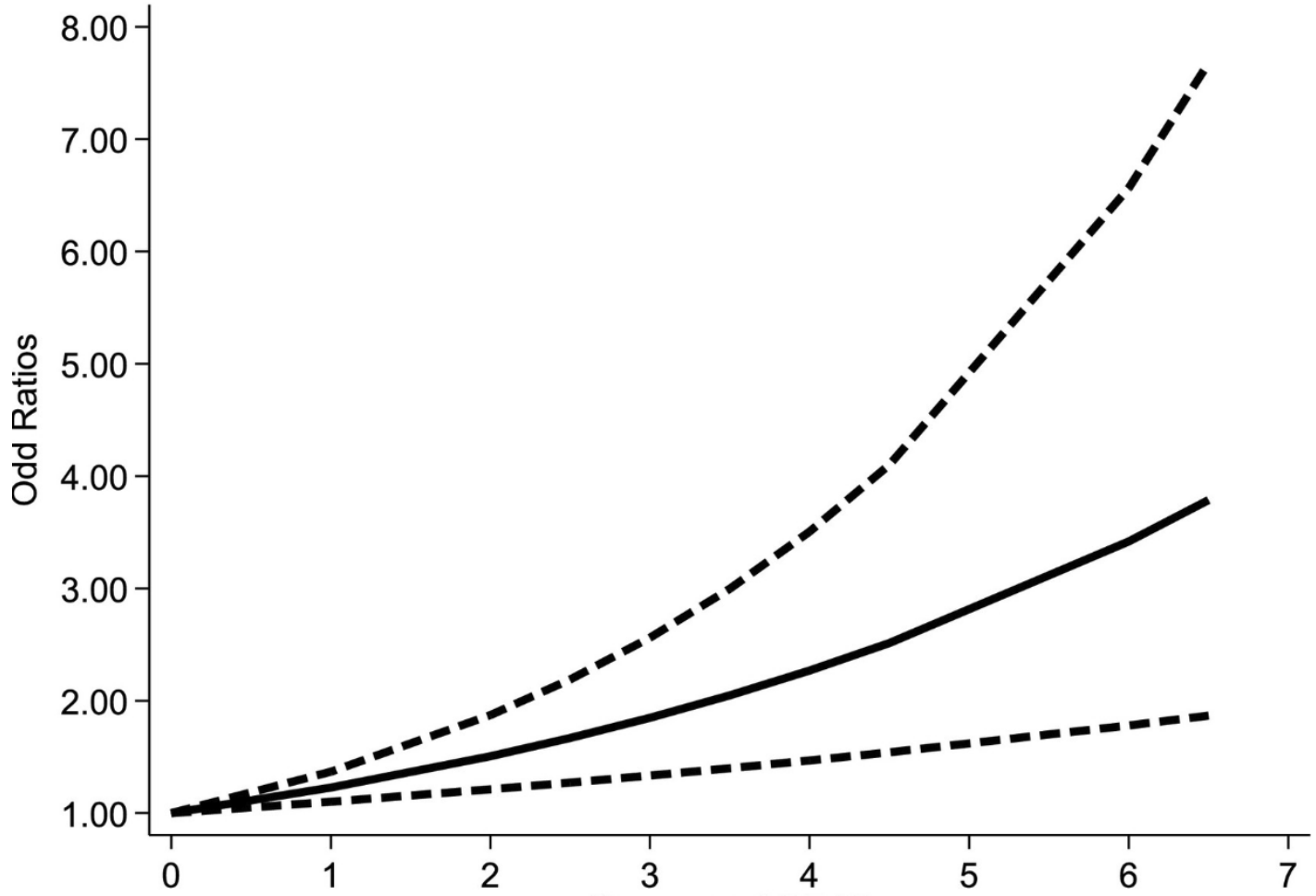
- Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature. Such events include, but are not limited to, directly experiencing natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness (e.g., a heart attack); witnessing the threatened or actual injury or death of others in a sudden, unexpected, or violent manner; and learning about the sudden, unexpected or violent death of a loved one.
- Following the traumatic event or situation, the development of a characteristic syndrome lasting for at least several weeks, consisting of all three core elements:
    - Re-experiencing the traumatic event in the present, in which the event(s) is not just remembered but is experienced as occurring again in the here and now. This typically occurs in the form of vivid intrusive memories or images; flashbacks, which can vary from mild (there is a transient sense of the event occurring again in the present) to severe (there is a complete loss of awareness of present surroundings), or repetitive dreams or nightmares that are thematically related to the traumatic event(s). Re-experiencing is typically accompanied by strong or overwhelming emotions, such as fear or horror, and strong physical sensations. Re-experiencing in the present can also involve feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event, without a prominent cognitive aspect, and may occur in response to reminders of the event. Reflecting on or ruminating about the event(s) and remembering the feelings that one experienced at that time are not sufficient to meet the re-experiencing requirement.
    - Deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s). This may take the form either of active internal avoidance of thoughts and memories related to the event(s), or external avoidance of people, conversations, activities, or situations reminiscent of the event(s). In extreme cases the person may change their environment (e.g., move to a different city or change jobs) to avoid reminders.
    - Persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Hypervigilant persons constantly guard themselves against danger and feel themselves or others close to them to be under immediate threat either in specific situations or more generally. They may adopt new behaviours designed to ensure safety (e.g., not sitting with ones' back to the door, repeated checking in vehicles' rear-view mirrors).
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.


Comparative Quantification of Health Risks
Global and Regional Burden of Disease Attributable to Selected Major Risk Factors
Volume 1
Edited by
Majid Ezzati, Alan D. Lopez, Anthony Rodgers and Christopher J.L. Murray
World Health Organization
Geneva
Chapter 23
Child sexual abuse
Gavin Andrews, Justine Corry, Tim Slade, Cathy Issakidis and Heather Swanston
CSA alters your life trajectory

I have already observed in the course of this judgment that I regard PTSD as an indivisible injury. It is far removed from, for example, industrial diseases such as noise induced deafness or asbestosis which are known to be dose related. That is simply not the case with PTSD. If I cannot say when the trigger for the PTSD occurred, it would not be logical to go on to conclude that, nevertheless, there can be an apportionment exercise. In any event, such would not be legitimate if my assessment is correct that this is an indivisible injury.

Leach v North West Ambulance Service NHS Trust
[2020] EWHC 2914 (QB)

Dose-Response Relationship



Unstandardized coefficients				Beta
Symptoms	B	SE	95% CI	β
PTSS	4.62	0.98	2.69–6.55	0.33
Anxiety	1.10	0.23	0.64–1.56	0.33
Depression	1.01	0.24	0.54–1.48	0.30
Eating Disorders	0.18	0.70	0.05–0.32	0.20
Insomnia	1.91	0.55	0.84–2.98	0.25
Nightmare distress	2.84	0.51	1.83–3.84	0.37
Physical pain	2.05	0.41	1.25–2.86	0.37
Emotional pain	0.74	0.18	0.39–1.08	0.31
Dissociation	2.74	0.63	1.50–3.98	0.30
Relational problems	0.83	0.22	0.41–1.25	0.27
Self-harm behaviors	0.87	0.21	0.46–1.28	0.29
Symptom complexity	0.28	0.08	0.13–0.42	0.29
Other measures				
Social support	−3.73	0.69	−5.10 to −2.35	−0.36
Hardiness	−1.13	0.38	−1.87 to −0.36	−0.22

Steine, I.M., Winje, D., Krystal, J.H., Bjorvatn, B., Milde, A.M., Grønli, J., Nordhus, I.H. and Pallesen, S., 2017. Cumulative childhood maltreatment and its dose-response relation with adult symptomatology: Findings in a sample of adult survivors of sexual abuse. Child abuse & neglect, 65, pp.99-111.

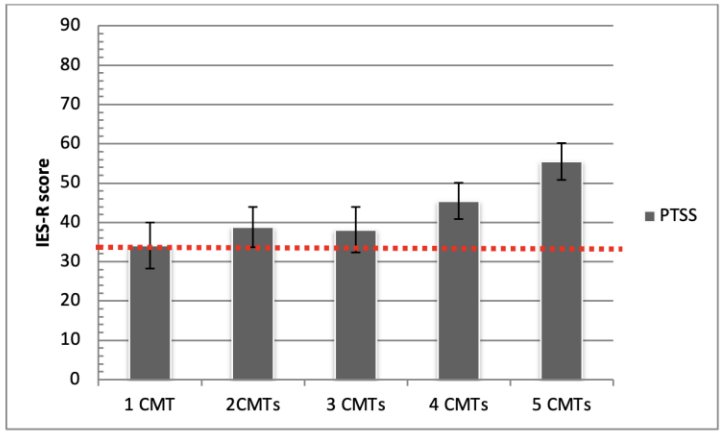


Figure 1a. Mean Impact of Event Scale-Revised *(IES-R)* score as a function of cumulative childhood maltreatment (CCMT). Dotted line represents ≥33 cutoff indicative of clinically significant PTSS. Error bars represent 95% confidence intervals.

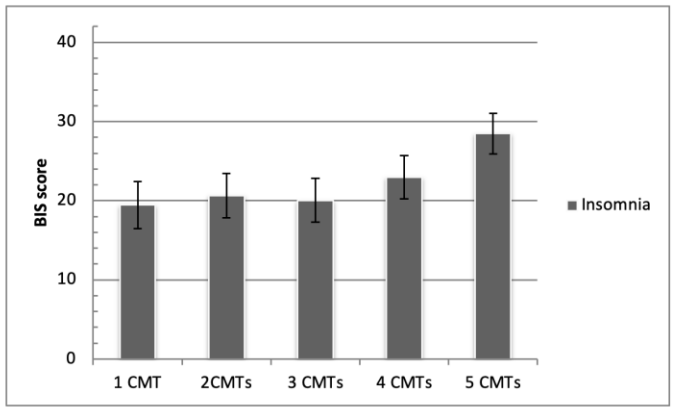


Figure 1d. Mean Bergen Insomnia Scale *(BIS)* score as a function of CCMT.

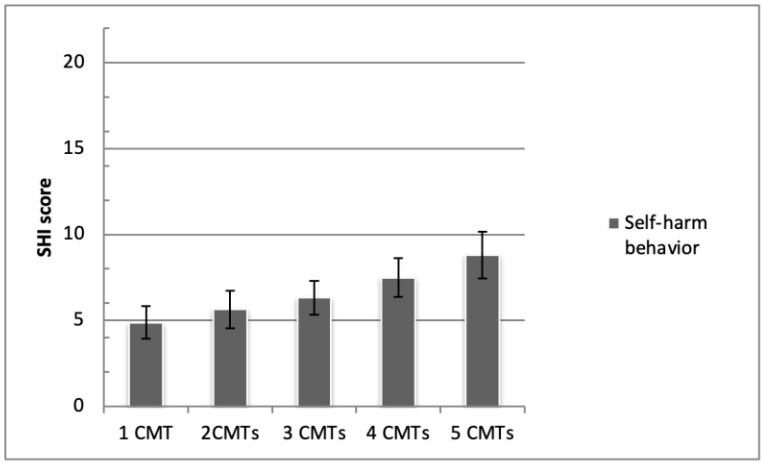


Figure 1f. Mean Self-Harm Inventory (*SHI)* score as a function of CCMT.

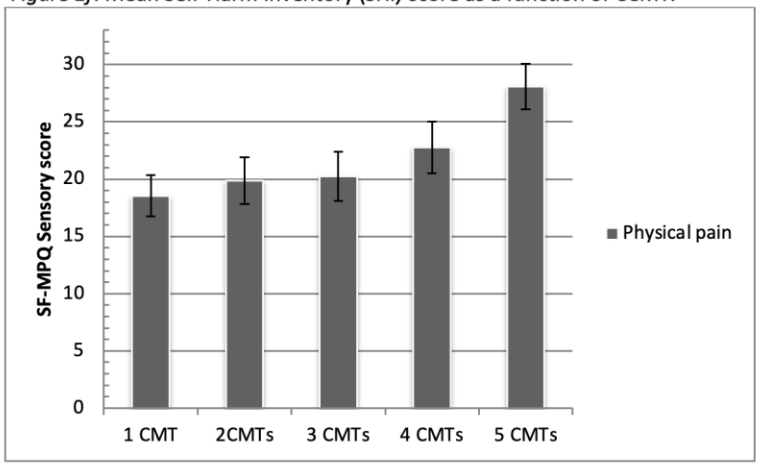
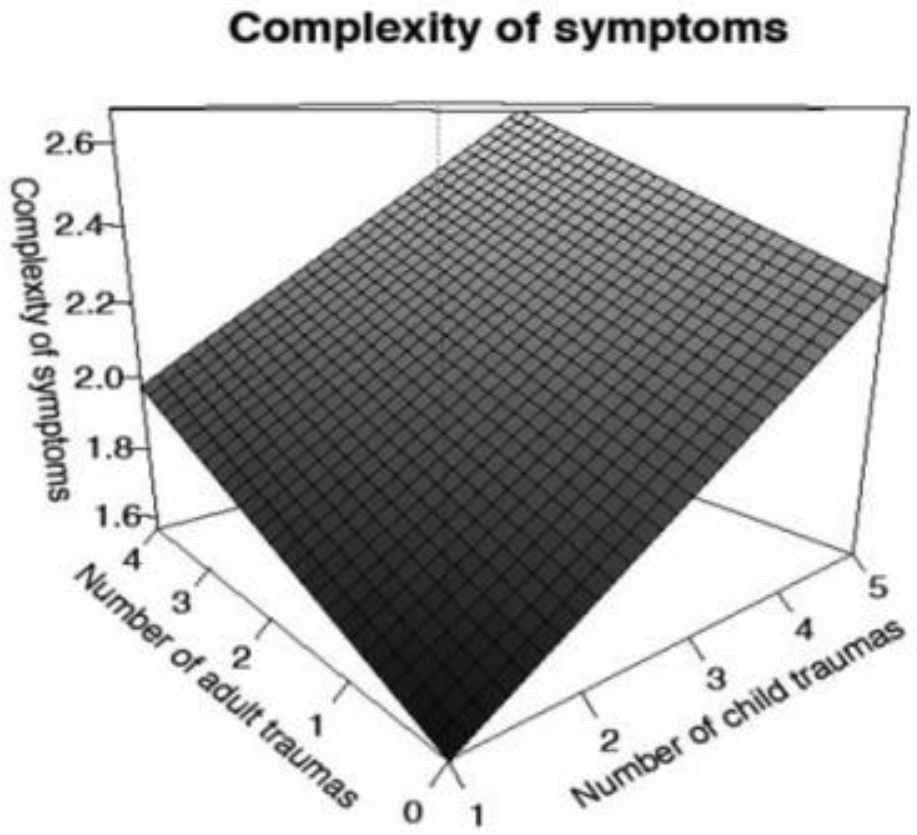
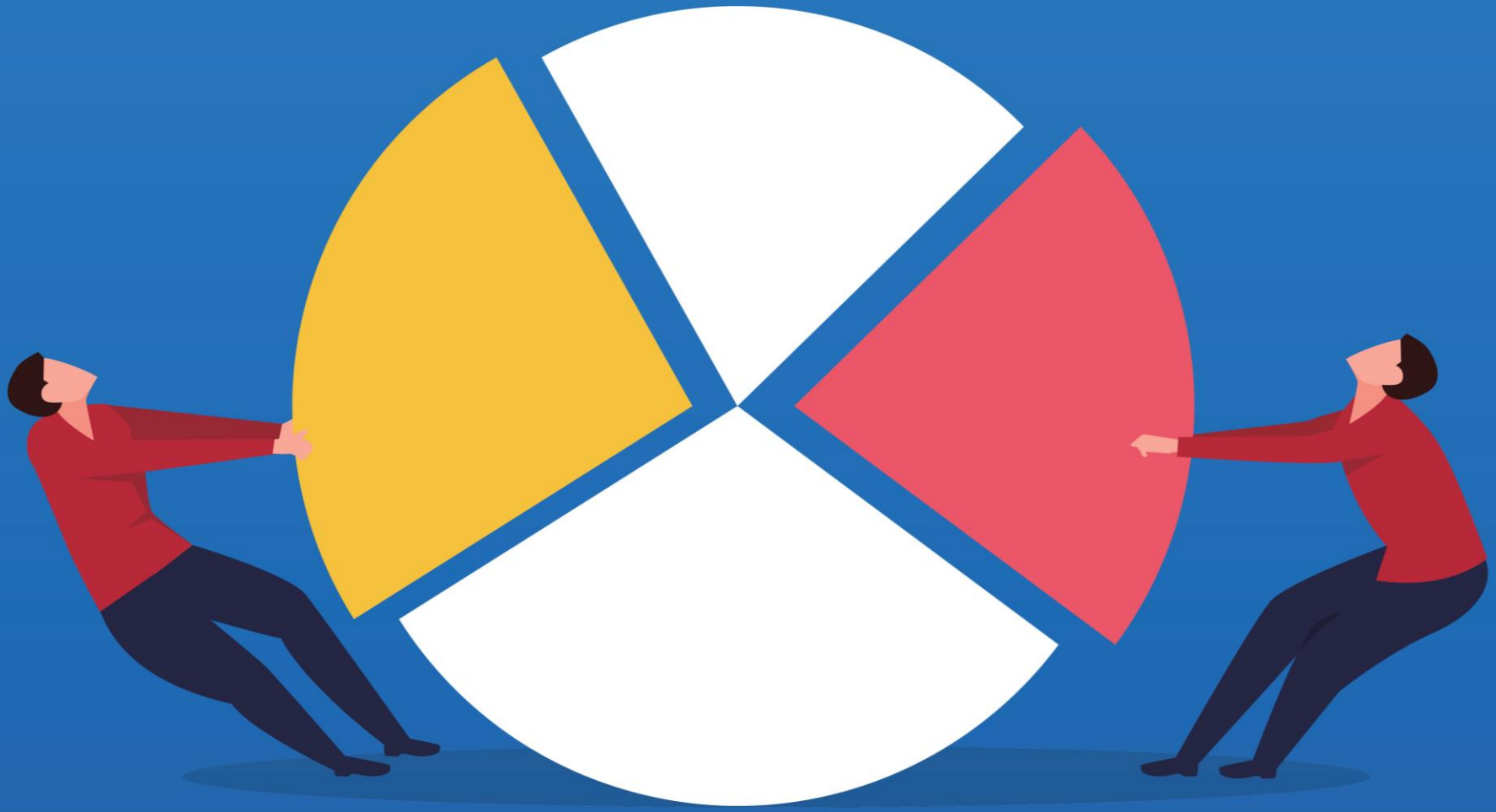


Figure 1g. Mean Short form McGill Pain Questionnaire *(SF-MPQ) Sensory* score as a function of CCMT.



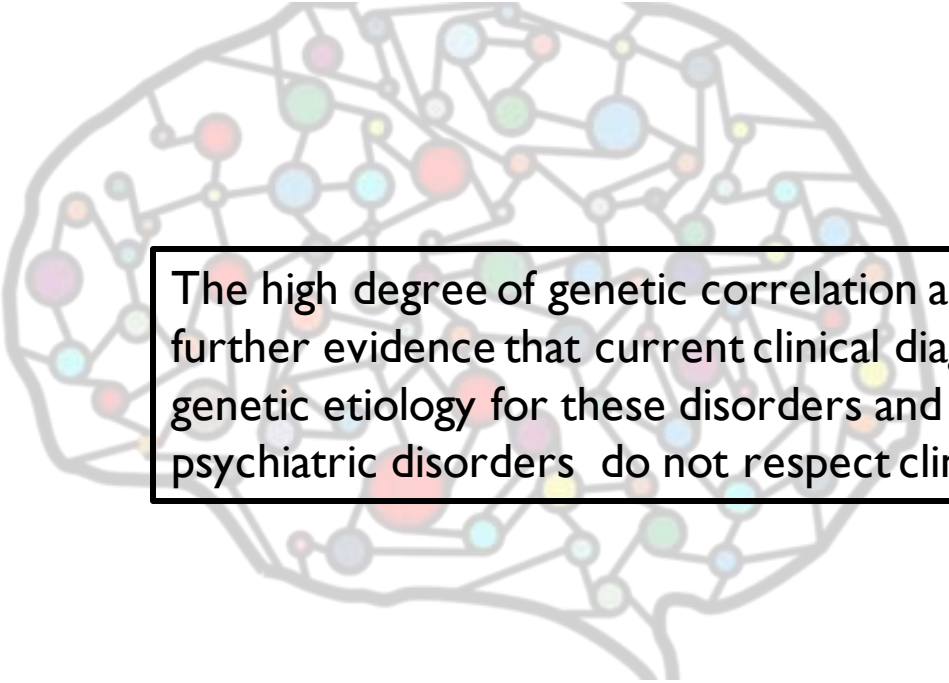
Cloitre, M., Stolbach, B.C., Herman, J.L., Kolk, B.V.D., Pynoos, R., Wang, J. and Petkova, E., 2009. A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. Journal of traumatic stress, 22(5), pp.399-408.



25% of all mental disorder presenting in adulthood is attributable to the experience of childhood adversity… with powerful and often sub-additive associations with the onset of many types of largely primary mental disorders throughout the life course

Green, J.G., McLaughlin, K.A., Berglund, P.A., Gruber, M.J., Sampson, N.A., Zaslavsky, A.M. and Kessler, R.C., 2010. Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. Archives of general psychiatry, 67(2), pp.113-123.

Genetics form part of a larger puzzle



The high degree of genetic correlation among the psychiatric disorders adds further evidence that current clinical diagnostics do not reflect specific genetic etiology for these disorders and that genetic risk factors for psychiatric disorders do not respect clinical diagnostic boundaries.

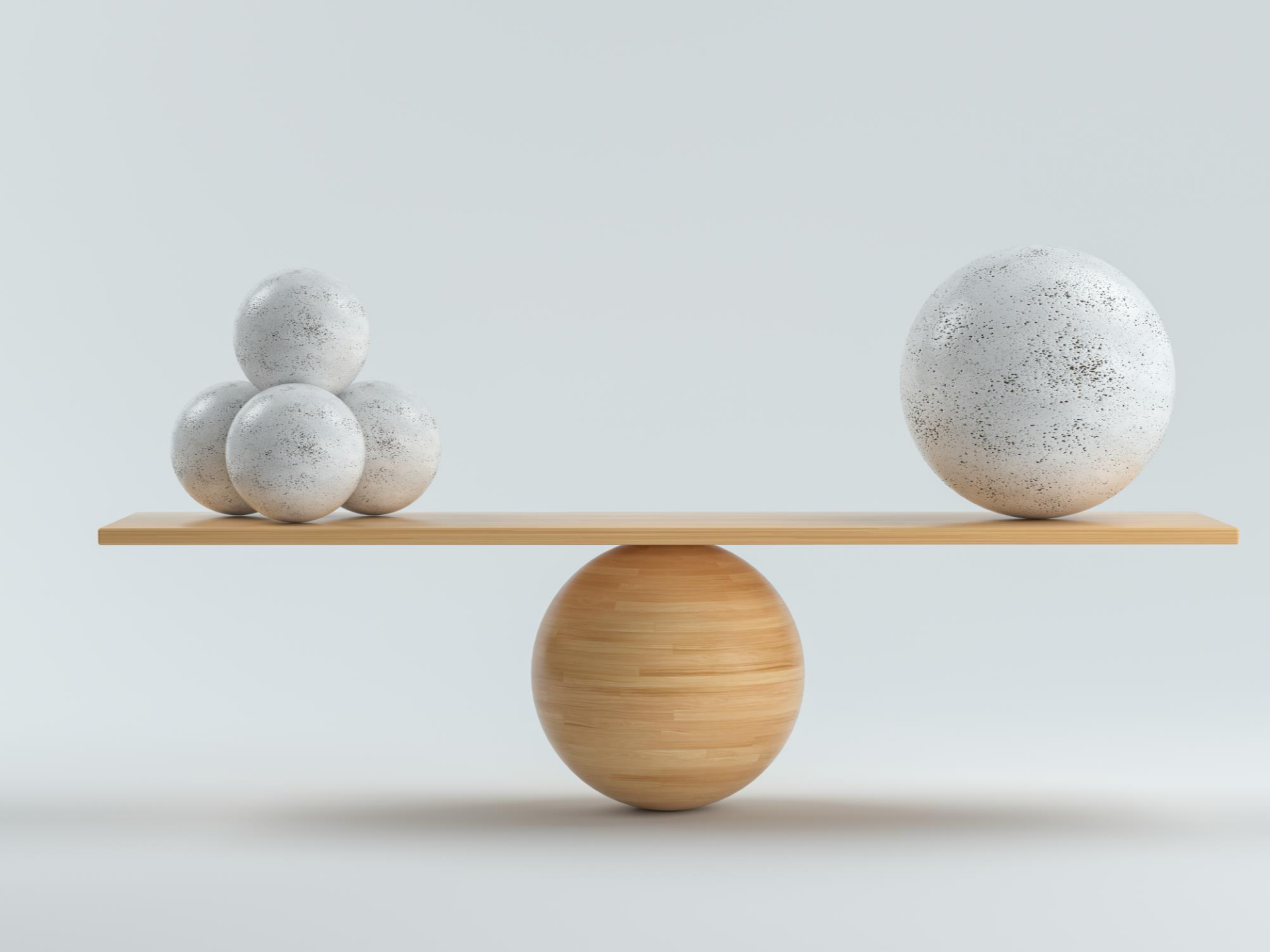
Brainstorm Consortium, Anttila, V., Bulik-Sullivan, B., Finucane, H.K., Walters, R.K., Bras, J., Duncan, L., Escott-Price, V., Falcone, G.J., Gormley, P. and Malik, R., 2018. Analysis of shared heritability in common disorders of the brain. Science, 360(6395), p.eaap8757.

Delayed-onset PTSD, traditionally defined as PTSD that develops at least 6 months after exposure to trauma, has been described for many years, with cases of PTSD reportedly commencing decades after the trauma occurrence. Systematic reviews indicate that, of those people who develop PTSD, approximately 25% may be delayed onset cases".

Bryant, R. A. (2019). Post-traumatic stress disorder: A state-of-the-art review of evidence and challenges. *World Psychiatry*, 18(3), 259–269

Experiential avoidance – person unwilling to remain in contact with private experiences such as bodily sensations, emotions, thoughts, memories – and takes steps to alter the form or frequency of the contexts that occasion them.

Hayes, S. C., Wilson, K. G., Gifford, E.V., Follette, V. M., and Strosahl, K. (1996). Experiential avoidance and behavioral disorders: a functional dimensional approach to diagnosis and treatment. J. Consult. Clin. Psychol. 64:1152. doi: 10.1037/0022-006X.64.6.1152



Underlying process opinion can be more helpful

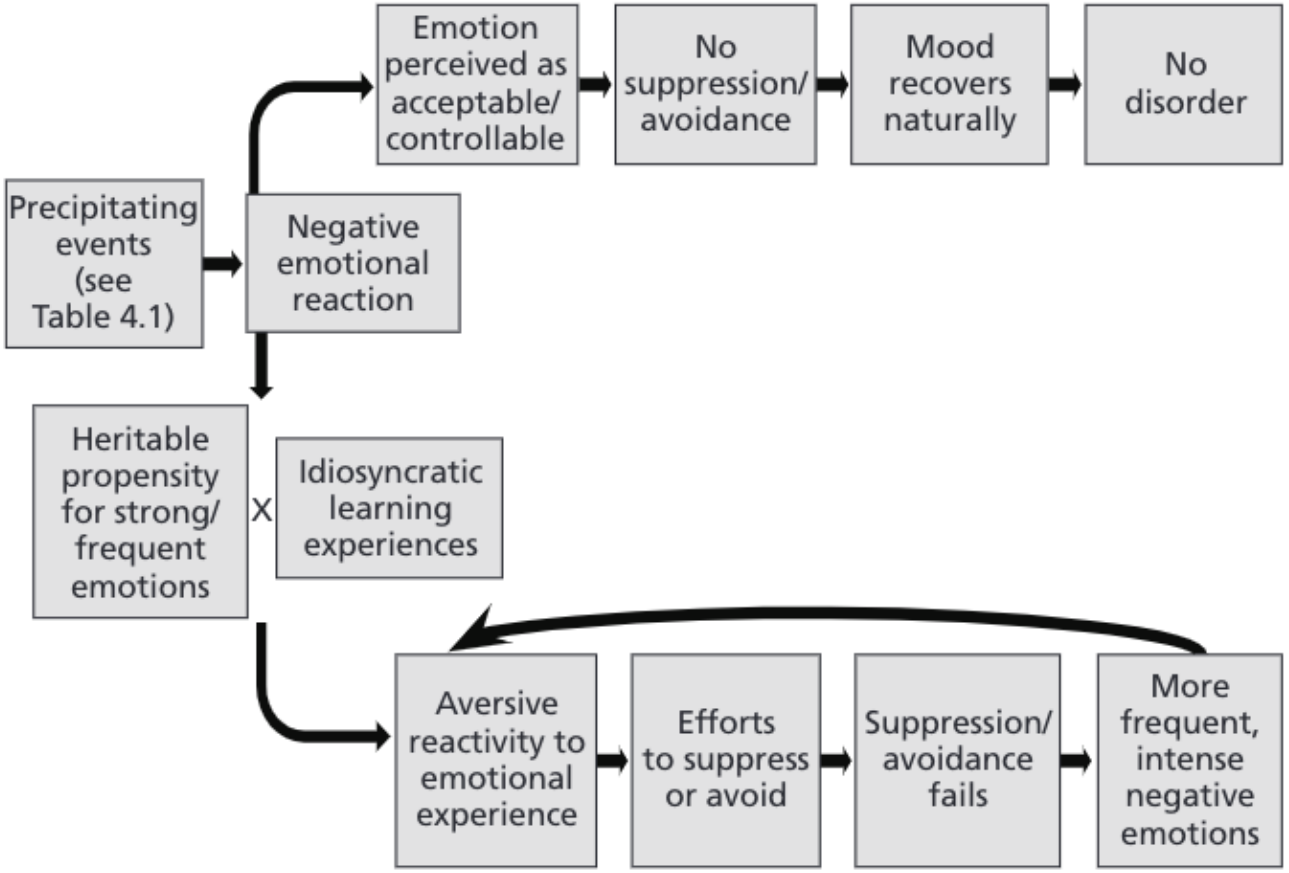
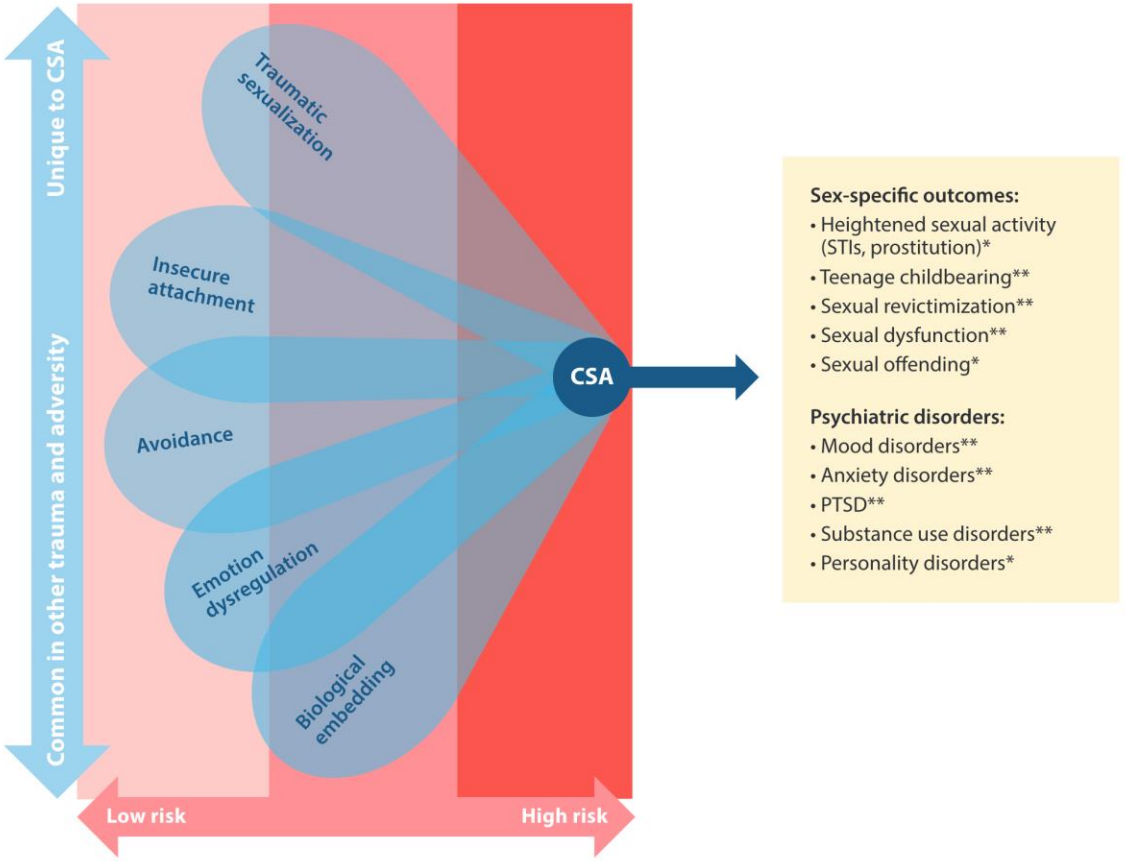


FIGURE 4.1. Model of mechanisms leading to the persistence of emotional distress and emotional disorders vs. normal emotional experience. Reprinted with permission from Bullis et al. (2019).

PTSD as a Faulty 'Brain Brake' - suppressing traumatic memories is like using a broken brake (the system meant to control them).

Mary, A., Dayan, J., Leone, G., Postel, C., Fraisse, F., Malle, C., Vallée, T., Klein-Peschanski, C., Viader, F., De la Sayette, V. and Peschanski, D., 2020. Resilience after trauma: The role of memory suppression. Science, 367(6479), p.eaay8477.



The CCM model of the risk that CSA confers on psychiatric disorders and sex-specific outcomes. Lower risk is associated with singular or independently occurring mechanisms; higher risk is associated with multiple or co-occurring mechanisms

Noll, J.G., 2021. Child sexual abuse as a unique risk factor for the development of psychopathology: The compounded convergence of mechanisms. Annual review of clinical psychology, 17, pp.439-464.


There is no contemporaneous record of this ever having been diagnosed, mentioned, recorded…

Signs and symptoms of mental disorders (particularly where there are issues re trauma, sensitivity and stigma) are commonly not recognized or fully documented in primary care settings.

Signs and symptoms of mental disorders (particularly where there are issues re trauma, sensitivity and stigma) are often not recognized or documents in primary care

Around 50% of mental health problems are identified in primary care

"Mental health care involves various sensitive information practices, such as people sharing a range of sensitive and potentially stigmatizing information, from personal trauma to behavioral patterns. This information can also be considered stigmatizing, both publicly and within health care settings."

Kariotis, T.C., Prictor, M., Chang, S. and Gray, K., 2022. Impact of electronic health records on information practices in mental health contexts: scoping review. Journal of Medical Internet Research, 24(5), p.e30405.

Gleeson, M., Hannigan, A., Jamali, R., Lin, K.S., Klimas, J., Mannix, M., Nathan, Y., O'Connor, R., O'Gorman, C.L.O.D.A.G.H., Dunne, C. and Meagher, D., 2016. Using electronic medical records to determine prevalence and treatment of mental disorders in primary care: a database study. Irish Journal of Psychological Medicine, 33(1), pp.3-12.

In 105 consultations where clinical notes and audio recordings were collected there were 636 documentation errors – 181 entries that did not take place and 455 findings not charted

Table 1. Distribution and types of errors across sections of the physician's note

Section of note	Number of errors (% of total errors)	% Commissions by section	% Omissions by section	% Clinically significant by section	% Category 1 by section
Chief Complaint	6 (1%)	17%	83%	100%	100%
HPI	119 (19%)	21%	79%	97%	85%
PMH/PSH	61 (10%)	12%	89%	92%	30%
Immunizations	19 (3%)	21%	79%	100%	0%
FH/SH	184 (29%)	21%	79%	63%	22%
Allergies	25 (4%)	24%	76%	100%	0%
Meds	32 (5%)	28%	72%	88%	78%
ROS	90 (14%)	73%	27%	99%	32%
Vitals	3 (1%)	33%	67%	33%	100%
Physical Exam	10 (2%)	40%	60%	70%	0%
Plan	87 (14%)	23%	77%	76%	30%
Total (all sections)	636 (100%)	29%	72%	83%	39%

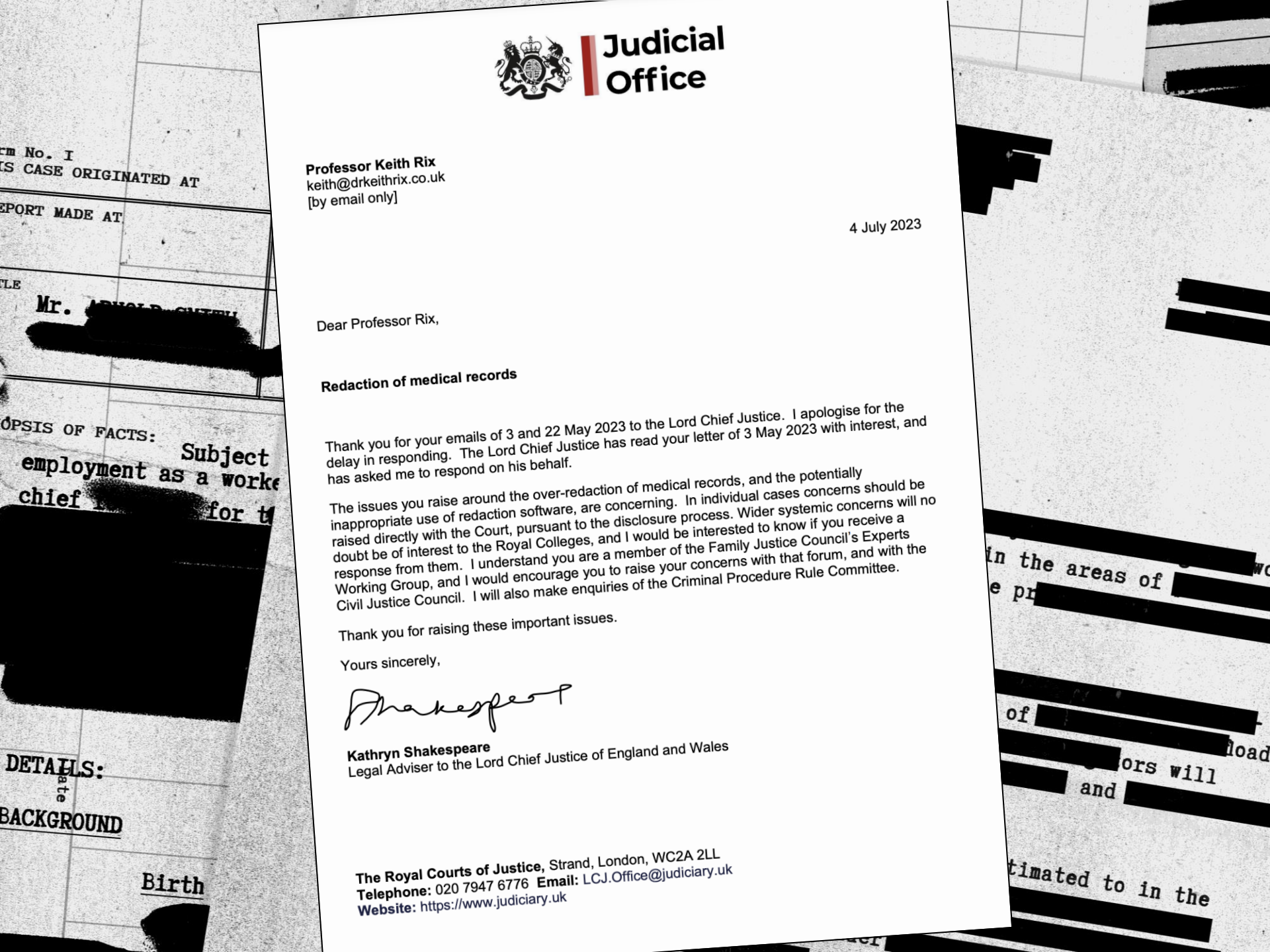
Abbreviations: FH/SH, family history/social history; HPI, history of present illness; PMH/PSH, past medical history/past surgical history; ROS, review of systems.

Weiner, S.J., Wang, S., Kelly, B., Sharma, G. and Schwartz, A., 2020. How accurate is the medical record? A comparison of the physician's note with a concealed audio recording in unannounced standardized patient encounters. Journal of the American Medical Informatics Association, 27(5), pp.770-775.

Table 2. Examples of documentation errors of omission and commission in each section of the physician's note

Section of note	Omission (Case)	Commission (Case)
Chief Complaint	Audio: Diabetic patient describes feeling "woozy" with "pounding chest" during presyncopal event Note: These symptoms not documented. (C)	Note: Physician documented patient "has no complaints at this time," but he was never asked. Audio: Patient reported weight loss later in visit, which was not documented (error of omission). (D)
HPI	Audio: Hypothyroid patient mentions last 3 periods have been heavier than normal. Note: Not documented (B)	Note: "Denies abdominal pain, fevers, or chills" in patient with unexplained weight loss. Audio: Patient was not asked nor volunteered the information. (D)
PMH/PSH	Audio: Patient reported she injured hip in car accident in 1972. Note: Not documented in patient presenting for hip replacement preop evaluation (B)	Note: "No history of heart or lung disease." Audio: Patient was never asked despite seeking preoperative assessment for hip transplant." (B)
Immunizations	Audio: Patient with diabetes declines pneumococcal vaccines. Note: Not documented (C)	Note: "Up to date on immunizations." Audio: Patient was never asked. (B)
FH/SH	Audio: Patient "stretching" his Pulmicort medication since loss of job. Note: Not documented despite poorly controlled asthma. (A)	Note: Documents asthma patient as "a smoker." Audio: Did not ask patient if he currently smokes. Asked if he smoked when younger, and he answered no. (Patient never smoked.) (A)
Allergies	Audio: Patient reported penicillin and nuts give him "a blotchy, itchy rash all over." Note: Not documented. (D)	Note: "NKDA" (No known drug allergies). Audio: Did not ask patient about allergies. (B)
Meds	Audio: Patient reports he started Novolog insulin 2 weeks before onset of hypoglycemic symptoms. Note: Not documented. (C)	Note: "OTC Med: 1 aspirin daily, Tylenol prn, 1 MVI daily." Audio: Patient did not report taking any of these medications. (B)
ROS	Audio: "No fevers, chills, night sweats" heard. Note: Not recorded in note. (D)	Note: "No SOB" (part of an all-negative ROS). Audio: No ROS questions asked; patient reported he was SOB which was noted in HPI. (A)
Vitals	Audio: Physician notes patient has normal BP despite reporting history of hypertension. Note: BP not documented. (B)	Audio: Physician tells patient BP is 120/60 on repeat. Note: 113/69* (B) *Not clinically significant. (B)
Physical Exam	Audio: Arthritic changes in knee joint.* Note: Not documented. *Category 2: Not related to chief complaint. (D)	Note: "feet with no CCE" (ie, clubbing, cyanosis, edema). Audio: Patient never instructed to remove shoes. (C)
Plan	Audio: Physician twice tells patient he needs to start taking aspirin daily. Note: Not included in plan, which listed other medications to start. (C)	Note: "Foot care recommendations given" in patient with diabetes. Audio: Not heard on audio. (C)

Abbreviations: FH/SH, family history/social history; HPI, history of present illness; PMH/PSH, past medical history/past surgical history; prn, as needed; ROS



Judicial Office

Professor Keith Rix
keith@drkeithrix.co.uk
[by email only]

4 July 2023

Dear Professor Rix,

Redaction of medical records

Thank you for your emails of 3 and 22 May 2023 to the Lord Chief Justice. I apologise for the delay in responding. The Lord Chief Justice has read your letter of 3 May 2023 with interest, and has asked me to respond on his behalf.

The issues you raise around the over-redaction of medical records, and the potentially inappropriate use of redaction software, are concerning. In individual cases concerns should be raised directly with the Court, pursuant to the disclosure process. Wider systemic concerns will no doubt be of interest to the Royal Colleges, and I would be interested to know if you receive a response from them. I understand you are a member of the Family Justice Council's Experts Working Group, and I would encourage you to raise your concerns with that forum, and with the Civil Justice Council. I will also make enquiries of the Criminal Procedure Rule Committee.

Thank you for raising these important issues.

Yours sincerely,

Kathryn Shakespeare
Legal Adviser to the Lord Chief Justice of England and Wales

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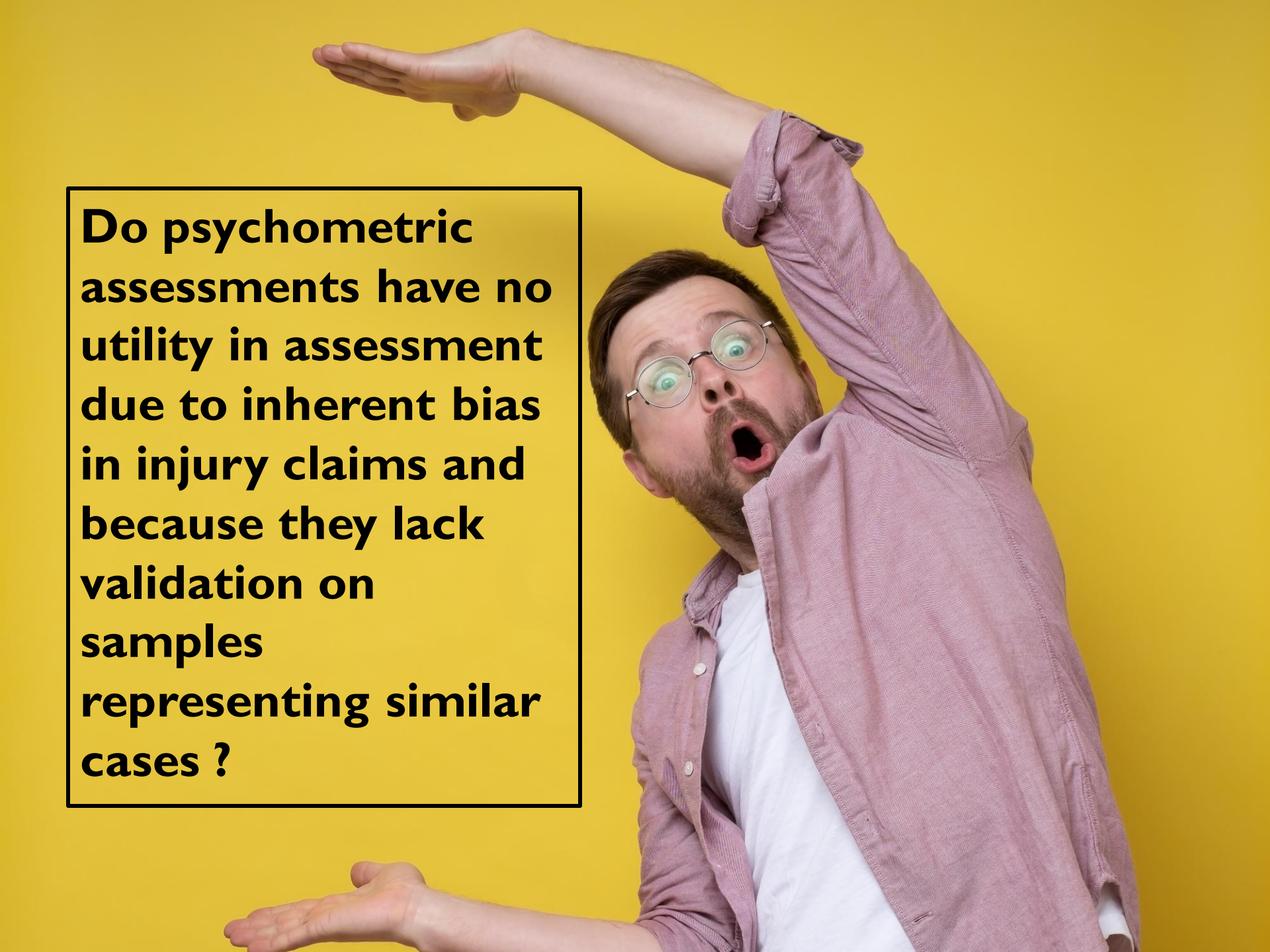
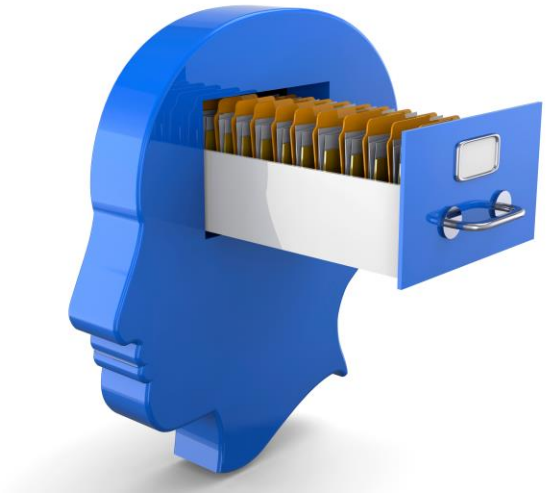
Accurate verbatim quotation is essential to support analysis of psychological process and impact

When pursued in cross examination it was revealed that extensive parts of the report which purport, by the conventional grammatical use of quotation marks, to be direct quotations from the Mother, are in fact nothing of the kind. They are a collection of recollections and impressions compressed into phrases created by Dr Harper and attributed to the Mother. They convey to the reader of the report only one impression, namely that they represent the authentic voice of Mother herself. ……Within the context of the evaluative exercise that the Court is involved in, during care proceedings, the accurately reported phrases and observations of the parties themselves are inevitably afforded much greater forensic weight than e.g. opinion evidence, hearsay or summary by a third party.

Re F (a minor) [2016] EWHC 2149 (Fam)


Do psychometric assessments have no utility in assessment due to inherent bias in injury claims and because they lack validation on samples representing similar cases ?



- No psychiatric explanation for new allegations arising at such a late stage.
- Unreliable memory over time
- Memories have become distorted with time to fit beliefs
- Events acquired new significance
- Retrospective re-attribution and reconstruction
- Finding patterns where none actually exist

The British Academy

Legal aspects of memory

A summary of scientific evidence issued by the Psychology and Law Sections of the British Academy

Published as an annex to

Baddeley, A., Brewin, C.R., Davies, G.M., Kopelman, M.D. & MacQueen, H.L. (2023), 'Legal aspects of memory: a summary of scientific evidence issued by the Psychology and Law Sections of the British Academy',

Journal of the British Academy, 11: 95–97. https://doi.org/10.5871/jba/011.095

The British Academy

Legal aspects of memory

We tend to remember what we consider **important.**

Inability to remember an event can be due to **encoding, storage, or retrieval** failures.

Events that are **repeated, distinctive or traumatising are better recalled** then others. **Central, distinctive, and personally significant** aspects are more likely to be remembered, especially if they involve **novelty, stress, trauma, or pain.**

If memories are reported to have been 'recovered', it is important to consider whether the Pursuer's description of their memory is consistent with scientific findings about what, given their age and the nature of the event, could reasonably be expected to be remembered and the way it is remembered.

When there is a delay between an event and being asked about it, **memory can adapt each time it is retrieved**, so changes and minor contradictions over time are to be expected.

Although **memory for the gist of an event tends to be accurate and long-lasting**, all memories fade over time.

"All PTSD symptoms are, by definition, intrinsically linked to a specific traumatic event, and symptoms either appear as **direct, real-time reactions to event reminders"**

"….. symptoms are typically triggered by internal or external event reminders (i.e., intrusive symptoms or contextual triggers, respectively),

which, in turn, **trigger and perpetuate avoidance and negative alterations in cognitions and mood**".

Schnyder, U. and Cloitre, M., 2015. *Evidence based treatments for trauma-related psychological disorders*. Cham: Springer International Publishing.

The Significance of Hot Spots

Specific parts of trauma memory that cause high levels of emotional distress, that may be difficult to recall deliberately to mind, and that are associated with intense reliving of the trauma.

Grey, N., Holmes, E. and Brewin, C.R., 2001. Peritraumatic emotional "hot spots" in memory. Behavioural and cognitive psychotherapy, 29(3), pp.367-372.

"Perhaps more importantly he has never experienced flashbacks, nightmares or disturbing thoughts involving his mother or the period he spent in her care."

"Again I consider it of significance that the pursuer has no adverse memories and has never experienced flashbacks, nightmares or disturbing thoughts about his period at the home."

"To the contrary, on his, essentially unchallenged, evidence the flashbacks, nightmares and disturbed memories he has experienced throughout his life that have occasioned him difficulty in both development, interpersonal relationships and employment all relate to his time spent in the care of WQ and, more pointedly, the abuse of a sexual nature that he sustained over a lengthy period at that person's hands. It follows that I am satisfied on the balance of probabilities that the difficulties experienced by the pursuer in both his personal life and in relation to employment have been proved to be causally linked to the CSA perpetrated"

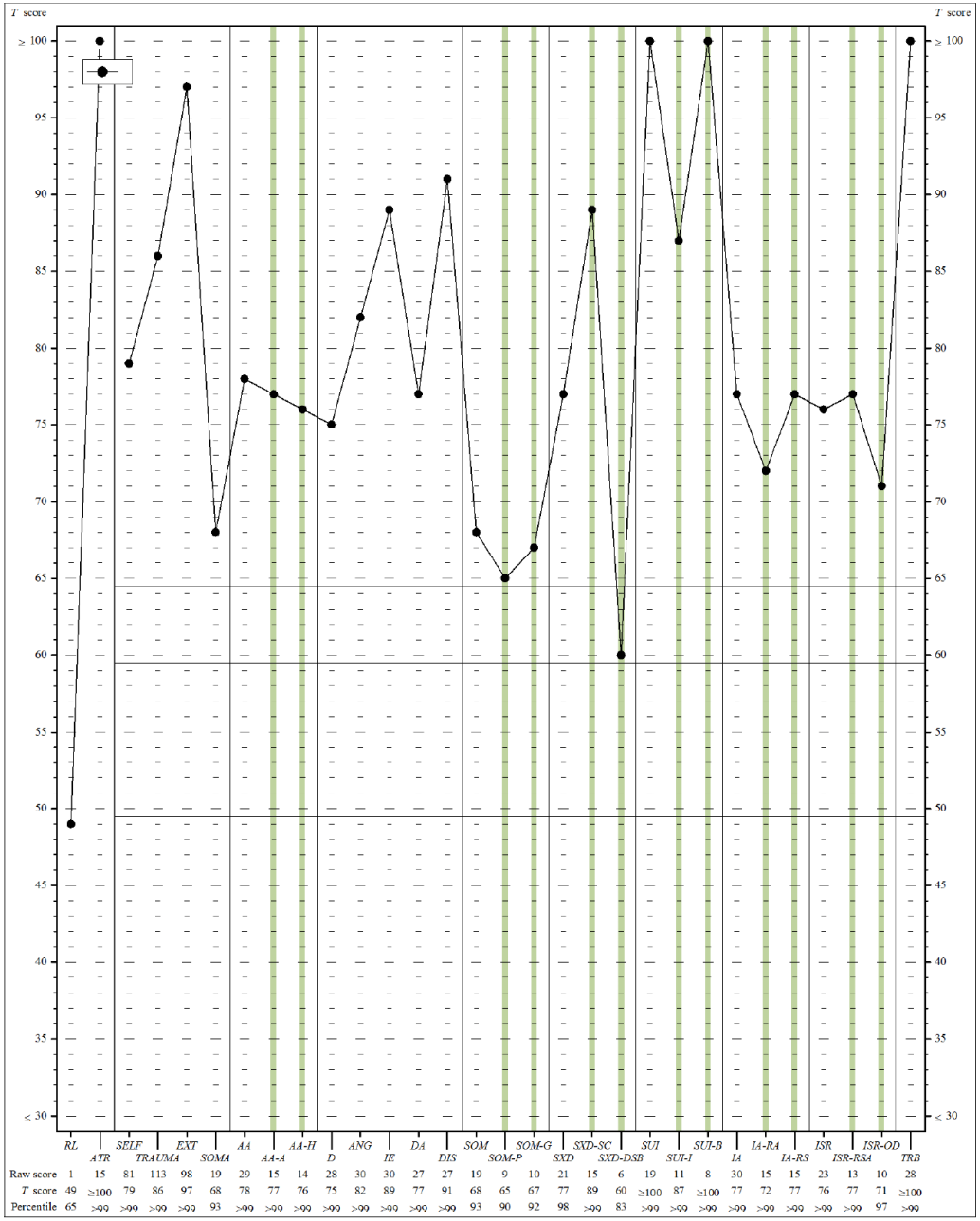
A v Glasgow City Council [2021] CSOH 102

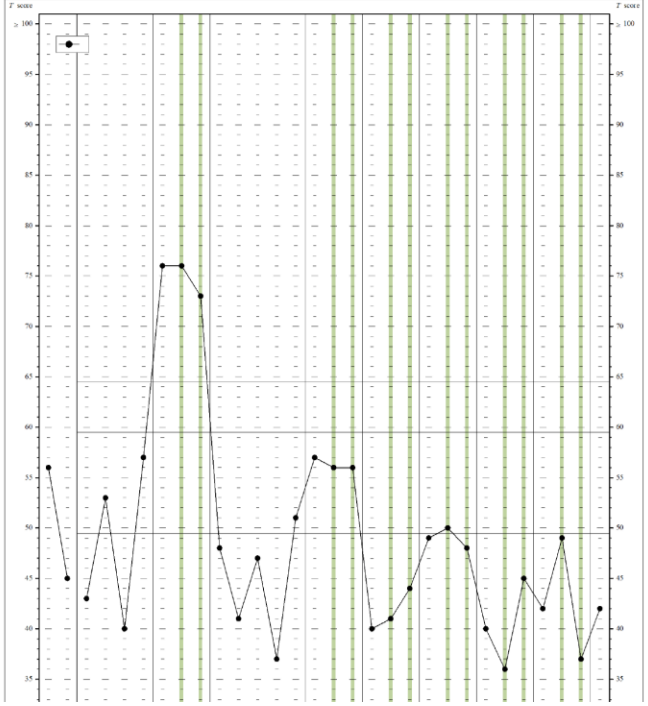
He also remembered the David Bowie song and I considered that was something that was likely to stick in a person's mind

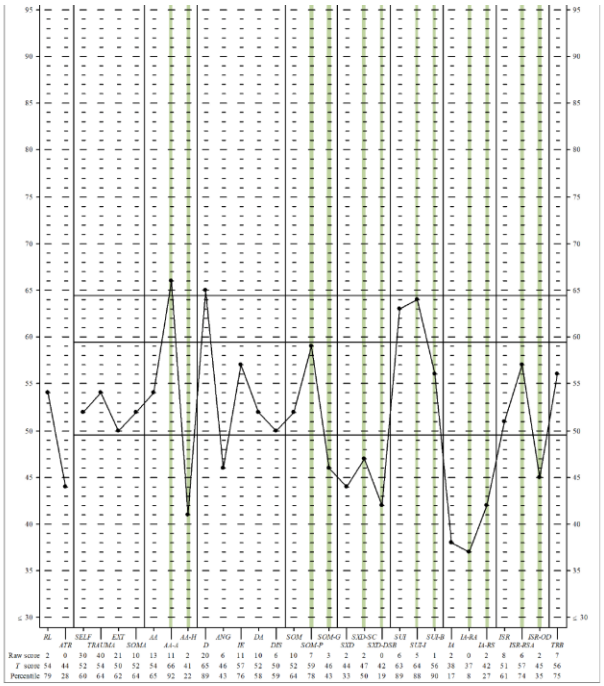
I considered the evidence showed that the pursuer had reoccurring nightmares related to the abuse (one of the Brother's coming into the dormitory), was reminded of the abuse when child abuse was mention (sic) in the news or in films, had intrusive thoughts during marital relations, engaged in social avoidance, was unable to talk about the abuse he suffered, had problems concentrating, had problems with sleep, had difficulties in establishing trust, was hyper vigilant and engaged in self destructive behaviour (in the form of substance misuse). I accepted these were symptoms of PTSD

AB v The English Provence of the Congregation of Christian Brothers [2022] SC EDIN 7

TSI-2 Profile







Conclusions

- Diagnosis as descriptor of nature and extent of essential features present and whether consistent with mental disorder beyond the boundary with normality
- Takes account of relationship and influence of processes relating to dose-response, memory, disclosure/experiential avoidance, convergence of mechanisms, memory, pathognomonic feature
- Takes account of the reliability and response bias for of ALL sources of information
- Focuses on the clinical plausibility of presentation
- Is informed by commitment to reflective practice and demonstrable commitment to maintain and extent knowledge within scope of expertise

Thank You

Professor Craig White
Email: profc@profc.org