MSBP AND MEDICAL EXPERT TESTIMONY

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Acknowledgement:
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MY BACKGROUND

- medical sociologist/anthropologist
- trained and experienced early childhood teacher
- trained counsellor
- PhD - experiences of parents of children with difficult to diagnose illness, with a focus on false accusations of MSBP
- Two post-doctoral fellowships - Social Justice and Social Change Research Centre, UWS
- Tutor/lecturer in medical sociology, research methods and ethics: “Ethical and Legal Issues in Health Care”.
MSBP and its latest reincarnation, Fabricated and Induced Illness, should be regarded as equivalent, despite semantic arguments to the contrary.

The term MSBP is used to describe an individual (usually mother) who purportedly induces or exaggerates illness in her child to gain attention from the medical profession.
MSBP AS JUNK SCIENCE

- MSBP experts in dispute: terminology (disorder, diagnosis, syndrome, behaviour) - ‘semantic reincarnations’ (name changes), paediatric versus psychiatric domains
- MSBP/FII is based on speculation, faulty research methodology and personal prejudice of practitioner (Meadow’s original *Lancet* 1977 article, recent *BMJ* website, Schreier statement
Some parents may harm their children in the medical context, however this is extremely rare.

Even if one insists on its existence, then using Bayes’s Theorem, (Mart 2002), MSBP is rare and therefore most accusations of MSBP are going to be false.

Profiles and unscientific labels must be abandoned in favour of robust evidence - if it is poisoning or suffocation, call it that.

Opinion must not REPLACE or OBSCURE FACTS in court.
Many miscarriages of justice have occurred and are still occurring, (particularly in the US and Australia). The Clark and Cannings cases in the UK have alerted us to widespread difficulties in medical expert testimony. This is occurring in both civil (child protection) and criminal courts.

There is no reason for specialists to be afraid of doing child protection work if they use correct protocol.

This presentation is a sociological perspective of medical expert testimony in the case of MSBP, with a focus on ‘pathways to error’.
THOSE AT RISK OF FALSE MSBP ACCUSATIONS

(in relation to the child)

• a child's illness cannot be easily diagnosed
• a child suffers an illness over which there is medical debate (e.g. ME/CFS, MCS, Lyme)
• a child suffers a vaccine or drug reaction (e.g. Cisapride)
• a child has been premature
• a child suffers reflux and gastro problems
• a child suffers problems after surgery
THOSE AT RISK OF FALSE MSBP ACCUSATIONS

• (in relation to the mother)
  • has accused a previous partner of sexually abusing her children (also Parent Alienation Syndrome)
  • makes complaints about medical negligence or is in a position to make a complaint about medical negligence.
  • asks too many questions about a child's medical care
  • indicates he/she is going to seek a second opinion
  • is assertive or engages in debate over treatment.
  • presents a child to hospital and interacts with specialists
  • visits alternative health practitioners
  • foster parent of child whose biological mother was drug addict or alcoholic.
1ST AND 2ND WAVES OF MSBP ACCUSATIONS

• **1st Wave:**
  - Children with CFS/ME
  - Children with gastric, failure to thrive, particularly those who underwent fundoplication
  - Children with allergies and/or multiple chemical sensitivities

• **2nd Wave:**
  - Children with Lyme disease
  - Children with autism and or autistic spectrum disorders
My examination shall focus on *pathways to error*:

1. The unexamined and ‘blurred’ relationship of expert testimony in criminal and civil courts (child protection proceedings).

2. Issues relating specifically to children’s courts (child protection proceedings).

3. Wider sociological issues relating to medical and child protection policy/practice as it impacts upon testimony in civil and criminal contexts.

4. Possible remedies for difficulties

5. Parents’ voices
MSBP AS A CASE STUDY IN MEDICAL EXPERT TESTIMONY

CRIMINAL AND CIVIL CASE STUDIES AT THE END OF THE PAPER PROVIDE FURTHER ILLUSTRATION AND DETAIL RELATING TO KEY POINTS IN FIRST HALF OF PAPER
1. RELATIONSHIP BETWEEN CRIMINAL AND CIVIL

*Differences:*
Criminal - ‘beyond reasonable doubt’
Civil (child protection) - ‘balance of probability’

The complex relationship of medical expert testimony in criminal and child protection cases needs to be closely considered in understanding faulty medical expert testimony in MSBP cases.
Artificial Inflation of Expert Reputation

Child protection cases, with a lower bar for evidence, may artificially inflate reputations of child protection experts, precluding accountability and leading to false credibility in criminal courts.

These experts may become accustomed to giving testimony of a lower standard of evidence, which they may transfer to the criminal court.

If this occurs with a witness of high esteem, scrutiny may be less than evident.
‘The prejudicial circle of innuendo and speculation’ - co-linked ‘theory’:

* Meadow’s Law refers to the notion that ‘one cot death is a tragedy, two is suspicious, and three is murder’. (erroneous)

* MSBP may occur in both civil and criminal courts, whereas Meadow’s Law usually occurs in the criminal courts.

* The ‘theories’ of MSBP and Meadow’s law are used co-jointly to further prejudice the case against an accused in the criminal courts.
Co-linked Experts:
‘Experts’ in Meadow’s Law or unnatural SIDS may also have ‘expertise’ in MSBP.
This enables the expert to infiltrate the criminal court with ‘theories’ such as MSBP, which have gained credence in lower courts with lower bars, but which would not pass standards such as the US ‘Daubert Test’.

Therefore, ‘junk science’ passes into the criminal court system as the expert moves seamlessly ‘to and fro’ between the two ‘theories’, which blur together.
D. THE INVISIBLE LABEL - PREJUDICE BY STEALTH

* MSBP may be referred to in evidence, even if the accused has not been directly assessed as a ‘MSBP case’ (e.g. Meadow in Sally Clark case).

* MSBP may be used to label the mother outside the court system, even if the label itself is not used in court. This is the ‘invisible label’, where profiling may occur without the specific label. It occurs by implication.

* In both situations the mother has generally been labelled MSBP and treated as a MSBP case without her knowledge and/or her lawyer’s knowledge.
E. THE EXPERT AS SYMBOL OF 'THEORY'

- Some high profile experts may symbolise a 'theory' such as MSBP - their appearance in court therefore symbolises the case as MSBP, creating prejudice, even if the ‘behaviour’ is not overtly raised in evidence or even if it has been ‘dismissed’.
- In this way the expert almost embodies the 'theory' - they become ‘as one’
- How to defend the unstated?
A FLAWED SYSTEM:

- Closed Courts
- The Taboo
- Alternative Risk of Harm - Witness Responsibility
- Hearsay evidence and ‘Spin’ Evidence
- Expert Witness Obstruction
- Medical Experts playing ‘judge’
- Over-Familiarisation
- Non Objective Representatives
CLOSED COURTS

• Whilst closed courts are intended to protect the identity of children, this means they are not open to public scrutiny. Courts operate in secrecy.

• A judicial system requires scrutiny. This is being partially acknowledged in the UK with recent civil case judgements involving children being made public with use of initials (e.g. Re LU and Re LB [2004] EWCA Civ 567)

• An open system will allow for a better standard of precedence in child protection proceedings.

• Support for open courts by Eric Pickles MP - motion to UK parliament
THE TABOO

- It is taboo to criticise child protection practices and child protection teams about ‘over-zealous’ errors e.g. wrongful removal
- The child protection system is therefore protected from open scrutiny in these types of cases
- For this reason, complaints made by parents about false accusations are not investigated adequately. Parents are also regarded as ‘liars’. Preliminary survey results: of 47 parent responses, approx 87% not satisfied with complaints process
- Therefore, serious issues with expert testimony are not appropriately addressed and remain embedded
Justice Wall states (Expert Witnesses in Children Act Cases): Para 5.4: (cited in BGMC findings re Southall):

‘You should be very cautious when advising a judge that in your opinion a particular event occurred. You should do this only if you feel you have all the relevant information’.

Southall scenario - Clark diagnosis via TV doco.
Meadow’s defence at disciplinary proceedings - ‘one does not hold oneself out as being an expert’ - Responsibility? (July 4, 2005)
ALTERNATIVE RISK OF HARM - WRONGFUL REMOVAL/ABUSE

• The lower standard of proof, ‘balance of probability’ in relation to risk of harm, ignores the alternative risk of harm -
  the emotional distress of an investigation and/or wrongful removal and possibility of abuse in foster home.

• An investigation is not a neutral or innocuous, benign event, but causes long lasting emotional harm in children (Underwager and Wakefield 1993).

• Some authors argue abuse is higher in foster care than in the general population (Wexler, 2004).
HEARSAY EVIDENCE AND ‘SPIN’ EVIDENCE

- Hearsay evidence is allowed in children’s courts. However, hearsay evidence of the parents seems to be disregarded, whereas hearsay evidence from expert witnesses seems to be regarded as fact.

- ‘Theories’ such as MSBP produce ‘spin’ - the ‘spin’ becomes the evidence - and the ‘spin’ tends to manipulate or even replace the facts.
When a child is removed on a temporary order, parents not given enough time to prepare for court. ('shock tactics' - Blakemore-Brown 2004)

Parents lose temporary custody of child - unable to take child to an independent doctor of their choice for an expert opinion. This obstructs a second opinion.

Therefore there is often only one expert or one team of experts (against the parents) as they are obstructed from getting their own expert - this means the sole expert is not open to scrutiny

Reason for failure of civil reviews in UK
In child protection cases, if a medical expert notifies against a parent, that expert’s opinion is taken as fact by social services, who usually do not undertake an independent investigation - despite findings of Butler-Sloss in Cleveland Inquiry (1988) - Mart 2002, Pragnell (n.d.).

The testimony of this expert is generally accepted as fact, when placed alongside the parent’s discredited narrative, therefore the medical expert becomes a ‘judge by proxy’, determining outcome of the case (Neustein and Lesher 2005).
As there are numerous child protection proceedings in the civil courts, some experts become well known to the courts.

There is a danger that this breeds an over-familiarisation between the judicial officer and the expert, who may develop an over-inflated credibility in this process.
• GALs (Guardian ad Litem) are regarded by parents as prejudicial and non-objective (11 out of 18 responses)

• The lawyers appointed to represent the children are regarded as prejudicial and non-objective by parents (13 out of 16 responses)

• Parents state that children are not consulted in relation to care arrangements (17 never consulted, 3 superficially out of 20 responses - vast age range of children involved)
4. WIDER SOCIOLOGICAL AND CULTURAL ISSUES

- Confirmatory Bias, Observer Effect
- Negation of parents’ evidence
- The Expert Witness of High esteem
- The Charismatic Expert
- The Problematic Basis of Expert Evidence: 'theory' and Process
- The ‘grey areas’ - role of orthodoxy - Cannings
- Taboo defences
- Risk and Moral Panic
- The Perfect World
- Ethical Erosion and Misogyny
A CULTURE OF CONFIRMATORY BIAS

• Confirmatory bias means that the expert adheres to his/her original hypothesis or belief, even when faced with evidence to the contrary (Mart, 2002, Risinger et al 2002).

• Confirmatory bias encourages generalists to go beyond their specific area of expertise e.g. a paediatrician giving evidence about microbiology, generalist child protection teams without adequate specialty knowledge (e.g. SBS case was actually microvesicular steatosis - CP team did not know what this was).
A CULTURE OF CONFIRMATORY BIAS

- Conformity effect, group think - juniors defer to seniors (Risinger et al 2002)
- Zealouts - the over-dogmatic expert (Butler-Sloss) - ‘the evangelical’ (Freckelton 2001)
- Dissent regarded as ignorance (Blakemore-Brown 2004)
- The judiciary found that the most serious problem with expert evidence was ‘Bias of expert’ (34.84%), followed by ‘failure to prove bases of expert opinions’ (13.93%) (Freckelton et al 1999)
Observer effect - related to confirmatory bias - are the desires and expectations people possess which affect analysis.

Not able to detect error in final interpretative document (testimony or report), error occurs in apprehension (the stage of initial perception), recording, memory, computation and the final interpretation (Risinger et al 2002).
NEGATION OF PARENT EVIDENCE

• Medical experts in MSBP cases may often negate or exclude the parents’ lay evidence (“anecdotal evidence”).

• Miller (2004) argues far greater credence should be afforded to lay evidence because scientific evidence is inherently unreliable, (especially when used to claim X does not cause Y which it is not designed to do). Lay witness testimony can be very reliable, can be tested and can equal or exceed science and expert evidence in reliability.
NEGATION OF PARENT EVIDENCE

- Parents’ evidence is discredited as ‘lies’ by the medical expert and is not heard, or regarded as less significant than expert evidence.

- Confirmatory bias exacerbates the negation of parent evidence.

- Miller (2004) argues that witness evidence is made to play second fiddle or not even taken into account.
THE MEDICAL EXPERT OF HIGH ESTEEM

- Witnesses such as Sir Roy Meadow were held in high esteem, and therefore their expert testimony was not placed under adequate scrutiny. The evidence of such experts may be treated as ‘proof’ rather than ‘evidence’ (Miller 2004) by both prosecution and defence.
- The evidence of the expert of high esteem may be given undue weight and contradictory evidence by other experts may be too easily dismissed.
- Those held in high esteem may be tempted to stray beyond their area of expertise by way of overconfidence e.g. Meadow and statistics.
• Generalisations without supportive evidence may occur e.g. Meadow’s Law itself or other contexts: E.g. Meadow in Anthony case: ‘It was doubtful that Jordan could have eaten a button herself, although it was possible that she could have picked it up and put it in her mouth. On the whole, babies aged less than 12 months rarely swallowed foreign bodies’. (Jordan was 11.5 mths)

• Warnings of possible unreliable evidence may be overlooked e.g. Meadow’s refusal to sign his evidence at Clark committal - that Dr Green had referred case of smothering where there was no blood in the lungs - despite tape-recording (Batt)
THE CHARISMATIC EXPERT

• There is a tendency for the expert who speaks with authority and who exhibits strong personal charisma in the witness box, to be believed over and above other witnesses.

• The content of the testimony should be the issue, rather than the manner in which it is presented.

• Other medical colleagues reticent to ‘go up against’ high profile ‘well performing’ expert or speak against other colleagues (esp in small medical communities such as those found in Aust)

• Secondary experts fly on the wings and prestige of high profile experts and their theories
‘Theories’ of ‘exclusion’ such as MSBP are oversimplistic and lead to simplistic evidence.

Recursivity of the medical literature - repetition does not equate with accuracy. Peer review may be a ‘lousy litmus test’ (Koukoutchos cited in McMullan n.d.)

The use of erroneous statistics (e.g. Meadow - Clark trial, Rosenberg - morbidity/mortality). Statistics afforded high status versus oral evidence of parents.

Contradictory/prejudicial profiling - Mart’s anti-profile (2002)
The assumption of guilt. If MSBP is a behaviour, which is known to be found in the general community, then this does not help us in determining the guilt of a specific individual (*R v LM* [2004] QCA 192).

The circular argument - How do you know she ‘has’ MSBP? - Because she did it - How do you know she did it? - Because she ‘has’ MSBP (*R v LM*, Mart 2002).

Difficulty of ‘falsifiability’ - a 'theory' which cannot be disconfirmed (Underwager and Wakefield 1993, Freckelton 2001).
Label is prejudicial rather than probative. The label implies the profile. A person should be charged with an offence or act, not a label, 'theory' or profile.

Strong evidence of prejudice - Legal Aid denied in civil and criminal (Dietrich principle - Moles 2004)

Multiple prejudice - prejudice builds on prejudice (previous history used to further prejudice case e.g. Clark)
• Parents assessed as ‘MSBP’ without clinical consultation - ‘Diagnosis by Immaculate Perception’

Schreier’s statement in Storck case - ‘’[such an interview would have served no useful purpose since he] cannot discern from parent interviews who is telling the truth and who is not…’’ (Bergeron 1996)

• There is a need to interview parents or practitioner risks being accused of not considering all aspects of case - (David, 2005, 2004)

• Assessment also made without seeing child
PROBLEMATIC BASIS OF EXPERT EVIDENCE: PROCESS

• Paper reviews/summaries are almost worthless - often based on other medical summaries or reports. Replete with errors without original documentation - (’Hearsay Squared’, David, 2005)
• In cases of child abuse, histories of cases may be deliberately misleading (David 2005)
• Psychiatric ‘diagnosis’ is renowned for being inaccurate - disagreement on diagnosis, plus inability to predict ‘dangerousness’ (Texas Defender Service Study - experts wrong 95% of the time - cited in Prejean 2005)
• Temptation for expert to use ‘retrospective inferences’ (Adshead 2005)
PROBLEMATIC BASIS OF EXPERT EVIDENCE: PROCESS

• Informal collusion of witnesses -
  Justice Wall: (Expert Witnesses in Children Act Cases): Para 10.5
  ‘What the court is anxious to prevent is any unrecorded informal discussions between particular experts which are either influential in, or determinative of, their views, and to which the parties of the proceedings do not have access.’

• False confessions made to expert - under duress/blackmail of losing children
PROBLEMATIC BASIS OF EXPERT EVIDENCE: PROCESS

• Economics - witnesses who make a living from giving evidence may tailor their evidence to the side which employs them, rather than first responsibility to the court.

• Economics - high cost of expert testimony - unequal resources - parents versus the State.

• The adversarial process itself (children’s courts proceedings are run in an adversarial manner despite the goal of an inquisitorial approach) - the need to win rather than find the truth.
Many cases involve illness conditions over which there is debate e.g. CFS/ME, Lyme disease, multiple cot deaths, MCS, vaccine damage.

New fields of expertise can be problematic under the ‘general acceptance test’ (Waye 1998). The ‘Daubert test’ would work against emerging knowledges which may explain a child’s illness and also be scientifically based. Peer review may actually exclude alternative viewpoints through editorial process (Miller and Miller 2005).
Miscarriages of justice occur when ‘the orthodoxy’ takes precedence and other theories dismissed.

‘Automatically rejecting dissenting views that challenge the conventional wisdom is a dangerous fallacy, for almost every generally accepted view was once deemed eccentric or heretical’ McMullan

MSBP cases may also involve rare diseases or uncommonly occurring events which may not have been considered in epidemiological data (now viewed as premium evidence - Miller and Miller 2005)

Significance of Cannings Judgement - need to accept that we may not always understand why a child dies or becomes ill.

The need to accept that medical knowledge is not finite.

The need to accept that there may be two different groups of experts who do not agree - if this is the sole basis of the case, then the case should not proceed (see below for further detail)
Some defences are regarded as taboo by medical orthodoxy, child protection practices, and also some members of the judiciary.

Parents are afraid to use a taboo defence in court, despite the fact that they believe it is the true and correct defence.

Some parents make ‘confessions’ to explain what has occurred, rather than confessing their belief about a taboo defence.

Expert witnesses who may support parents in a taboo defence may come under attack e.g. GP in the UK. This discourages such defences.
CULTURE OF RISK AND MORAL PANIC

- Beck - we live in a post-modern world of risk.
- High profile case studies induce moral panic and hysteria about dangerous mothers e.g. Allitt case (Clothier found not MSBP, Pragnell 1998)
- Erroneous logic - compare to Dr Harry Shipman - should all doctors also be suspected as killers?
- Moral panic leads to punitive culture and suspicion - most notifications of abuse unsubstantiated (generally around 85% - NSW AIHW 2004-5 88%)
- Compassion seen as suspicious and weak
- The importance of trust and social capital
In previous times, the death of infants was regarded as natural. With the lowering of infant mortality, deaths now regarded as suspicious. Babies and small children are not allowed to die.

Preventable deaths in hospitals (Wilson report 1995) - extrapolated number of deaths in 1992 - 18,000. Some preventable deaths occur in children’s wards - iatrogenesis rather than parent?

Mothers are supposed to be ‘perfect’ with ‘perfect’ children in a far less tolerant society. Mothers who produce sick or disabled children may be ‘blamed’ for this. Mothers with PND - MSBP.
ETHICAL EROSION

- Perjury (including ‘verballing’)
- Fabrication of evidence
- Tampering with files
- Exclusion of evidence e.g. Williams
  Goldsmith Nov 27, 2004: ‘if the expert only owns up to possible alternatives in cross-examination, then he risks showing himself as careless, inexpert - or worse - a charlatan’
- Bad faith allegations e.g. Biswas [2003] EWHC 2342 (Admin)
- Misogyny
POSSIBLE REMEDIES: ACCURACY AND SCRUTINY

- Open courts in children’s matters for scrutiny and setting of precedents.
- All medical summaries must be accompanied by original medical data.
- Stricter protocols for forensic pathology, microbiology, post-mortems etc.
- Working/backnotes should be included in pathology evidence, not just final results. Independent verification needed.
- No psychiatric/pediatric evaluations without clinical consultation with the family.
- Shift from ‘educated guess’ to ‘robust evidence’
POSSIBLE REMEDIES: ACCURACY AND SCRUTINY

• Removal of generalist child protection teams embedded in hospitals who go beyond areas of expertise and act as ‘spin middle-men’
• Use of highly trained specialists (more than one) from specific relevant areas of medicine, who are willing to confer, instead of generalist teams.
• Consultations by paediatricians for court purposes should be taped. If not possible, written notes of consult should be shown to parents, explained and signed by both parties. When draft report written, meet with parents and their lawyer to check for factual accuracy (Bamford 2005).
POSSIBLE REMEDIES: ACCURACY AND SCRUTINY

• Paper reviews should not be accepted from paediatricians, psychologists, psychiatrists or GPs, and should only be allowed in relation to interpretation of laboratory tests by specialists.

• Publication of child protection case judgements with use of initials to protect identity.

• Establishment of more specific case law in the child protection system with use of precedents via public judgements.

• All expert testimony, including that of eminent experts, needs to be placed under greater scrutiny.

• Cessation of use of labels and concomitant ‘spin’
POSSIBLE REMEDIES:
HEARING ALTERNATIVE VIEWS

• Lay judges and advocates are unable to easily assess medical issues - the cause of many problems (Miller 2006 pers com). For this reason, alternative, well researched, medical defences to the orthodoxy, including ‘taboo’ defences should be treated respectfully and considered.

• More access to expert witnesses for second opinions and for those who cannot afford witnesses.
POSSIBLE REMEDIES: HEARING ALTERNATIVE VIEWS

- Opposed to Joint expert witnesses and court appointed witnesses (Woolf Report, NSW Law Reform Commission Report 109) - won’t work in MSBP context - will follow orthodoxy and exclude alternatives - not suitable for complex medical matters - risk of blackmail

- Dissent should be encouraged (Sunstein 2003)

- Meetings to discuss differences of expert opinion.

- ‘Hot tubbing’ - concurrent evidence (Wilson 2005) is preferable in these contexts
POSSIBLE REMEDIES: TAKING RESPONSIBILITY

- Safeguards for the rights of families
- Better complaints processes - by independent bodies - cessation of self-investigation by authorities.
- If witnesses are found to give false or misleading information then court proceedings should be immediately halted and action taken.
- Penalties for false or inaccurate testimony (Berlin 2003) despite arguments re witness immunity. Disciplinary action by professional bodies rather than civil litigation.
POSSIBLE REMEDIES: TAKING RESPONSIBILITY

• Medical professionals should be encouraged to admit mistakes, apologise and rectify errors if possible (Woolf Report 1996) - eradicate bad faith allegations based on fear of being sued.

• Expert Witnesses must take responsibility for their testimony and consider carefully the consequences of wrongful removal or incarceration - otherwise many children will sue for wrongful removal. Re LU and Re LB [2004] EWCA Civ 567. Children in UK now suing for wrongful removal due to satanic rituals.
POSSIBLE REMEDIES: TAKING RESPONSIBILITY

• Listings to court by expert witnesses of previous cases where they have been an expert (previous misdeeds can be tracked by defence) - (Berlin and Williams 2000)
POSSIBLE REMEDIES: EDUCATION

- Legal officers should be educated about ‘fad theories’ without scientific basis.
- Legal officers must give credence to alternative medical opinions and lay evidence.
- Training techniques for medical professionals so patients, mothers and women are treated with respect rather than suspicion.
- Training techniques - expert witnesses to LISTEN to patient narratives AND alternative expertise.
- Training for medical professionals in expert testimony and the court process.
- Training in IMPORTANCE OF ACCURACY.
POSSIBLE REMEDIES: THE SYSTEM

- Reforms to traditions of adversarial system - legal reputations should be based on ethics, rather than number of ‘wins’ in court, where truth becomes subservient to reputations.
- Criminal Cases Review Commission in Australia so that miscarriages of justice can be rectified (Moles 2004).
- Protocol for review of child protection cases in similar manner to CCRC.
- Medical and Social Services Record Keeping systems should be immunised against alterations - systems which do not allow alterations after original entry.
‘The system in the UK is designed to close ranks against the accused. You are gagged by the family courts.’

‘Secrecy of family courts precludes justice. Protects professionals and does not allow for peer review of evidence.’

‘When it is one mother against doctors and social services, judge favours their statements and is ruled by them rather than looking at the whole scene.’

‘I was surprised child protection services were never prosecuted for lying under oath.’
• [The justice system] sucks.
• [The justice system] is slow, slow.
• ‘Child protection report contained contaminated evidence.’
• ‘There is no justice. As soon as MSBP was mentioned, we lost our son.’
PARENTS’ VOICES: HOW ACCUSATION AFFECTED THEM

• This devastated everybody. My daughter does not want to go to the doctor anymore. We try to go on with our lives but it is like we live in a prison.
• Shock, anxiety, panic, shame.
• Devastation, disbelief, stress, fear.
• I cannot trust anybody, depressed and anxious all the time.
• This has ruined a close family.
• Tremendous emotional distress, financial loss, bankrupt, disruption of a loving and caring family.
• I feel invalid and dirty.
• Unable to trust anybody, I feel like a prisoner.
DETAILS OF CASE STUDIES

THE FOLLOWING SLIDES GIVE DETAILS OF SIGNIFICANT CRIMINAL AND CIVIL CASES (CHILD PROTECTION)
CASE STUDIES: CRIMINAL

- *R v Sally Clark* [2003] EWCA Crim 1020; 2 FCR 447
- *R v Angela Cannings* [2004] 1 All ER 725
- *R v LM* [2004] QCA 192
- *R v Patel* (cited in [2004] EWHC 411 (Fam))
- *R v Donna Anthony* [2005] EWCA Crim 952

Comparison of these cases to:

- *R v Folbigg* [2005] NSWCCA 23
THE SALLY CLARK CASE

- Sally Clark, lawyer, was convicted in 1999 with the murder of her two children, Christopher and Harry, when they were a few weeks old. She spent three years in prison.
- First appeal dismissed in October 2000.
- Whilst Sally was not directly accused of MSBP, Meadow referred to MSBP in his evidence, thereby creating prejudice. ‘Meadow’s Law’ was the basis for his evidence against Sally.
SIGNIFICANCE OF CLARK CASE

• Highlighted serious faults in medical expert testimony and resulted in three medical professionals being found guilty of serious professional misconduct by the BGMC.

• Highlighted the fact that large economic, social and educational resources are needed in order to successfully defend charges such as these, and even then it is extremely difficult.

• ‘Taboo’ defences - unable to be fielded in court
ISSUES: SUCCESSFUL GROUNDS FOR APPEAL

- The failure of the prosecution to disclose microbiological evidence that rendered the convictions unsafe.

- The statistical information overstated, very considerably, the rarity of two SIDS in the same family.
Sir Roy Meadow, paediatrician, nephrologist, and originator of MSBP, was struck off the medical register on July 15, 2005.

- **Grounds:** Giving evidence outside his area of expertise and for conduct incompatible with what is expected from the medical profession.
- Meadow gave evidence in Sally’s trial that there was only a 1:73 million chance of two SIDS deaths occurring in the same family and used metaphor of backing the long odds winner of the Grand National race.
- Meadow is not a statistician or expert in SIDS.
DISCIPLINARY ACTION: MEADOW

• ‘You are an eminent paediatrician whose reputation was renowned throughout the world, and so your eminence and authority carried with it a unique responsibility to take meticulous care in a case of this grave nature. You should not have strayed into areas that were not within your remit of expertise.’

• ‘your misguided belief in the truth of your arguments, maintained throughout the period in question and indeed throughout this Inquiry, is both disturbing and serious.’
MEADOW’S DEFENCE AT DISCIPLINARY HEARING (2005)

- In relation to expertise in child abuse: ‘I do not hold myself out. I present my CV and leave others to judge’ ‘Some paediatricians provided a regular on-call service…so in that sense… I was not an expert in child abuse in my city.’
- Stated that he had never been shown written instructions in giving medical expert testimony.
- Stated he had quoted other experts’ statistics (CSEDI report) - yet did not use report’s caveats.
- Had been unable to produce evidence of original data from 1999 study - it had been shredded.
- Currently appealing in High Court
Dr Alan Williams, pathologist, was found guilty of serious professional misconduct on June 3, 2005 - banned from court work for 3 years.

Grounds: Undertaking faulty post-mortems on both Christopher and Harry, not disclosing important evidence at committal to police or prosecution, and not keeping proper records.

Evidence excluded: the children had died of the bacterial infection, staphylococcus aureus,

Chairman: ‘A fair trial hinged on your evidence. Your errors and omissions were formidable’.

Court of Appeal: Alteration of position(Rafshauge)
16. ‘You told the Panel that if experts for the Defence wished to have results for tests you considered not to be relevant, they should have asked for them; or that the Police gathering of records should have ensured that the microbiology results were available before the trial. The Panel was satisfied that you had an overriding responsibility to record those findings in your report.’
DISCIPLINARY ACTION: SOUTHALL

- Professor David Southall was found guilty of SPM on June 7, 2004 and banned from child protection work for 3 years.
- Grounds: Produced a report on the Clark family, stating that Stephen Clark had murdered his son, beyond reasonable doubt. This report was based on watching a TV doco, not based on any medical records, reports, investigations, lab results, post-mortems, x-rays or interviews with family. No caveat was provided to state the report undertaken with limited info. Undertaken during suspension.
- BGMC found his actions to be ‘inappropriate, irresponsible, misleading and abuse of profession’
SOUTHALL’S DEFENCE AT DISCIPLINARY HEARING:

• ‘The Committee are concerned that at no time during these proceedings have you seen fit to withdraw these allegations or to offer any apology’.

• This position contributed to the decision to suspend his professional duties.
Convicted on April 2002 of murder of her two sons, Jason, who died at 7 weeks in 1991, and Matthew, who died at 18 weeks, in 1999.

Acquitted of the murder of her two sons on December 2003.

Compensation initially denied.

Angela stated in BBC Real Life program, “Cherished” that she would prefer to have been in prison than lose her child to adoption in children’s courts.

Cannings and MSBP - supposedly dismissed
SIGNIFICANT ISSUE: LANDMARK JUDGEMENT

• 178. ‘if the outcome of the trial depends exclusively or almost exclusively on a serious disagreement between distinguished and reputable experts, it will often be unwise, and therefore unsafe, to proceed.’

• Medical knowledge is not finite. Many new genetic illnesses discovered every year. Cannings’ grandmother experienced two infant deaths. Dairy allergy in extended family.

• An exclusion argument should not be used - if we don’t know what has caused the death (or illness), then the mother should not be automatically blamed.
SIGNIFICANT ISSUE: WARNING ABOUT EXPERTS

• Standing of Meadow’s reputation queried:

• 17. …the flawed evidence he gave at Sally Clark’s trial serves to undermine his high reputation and authority as a witness in the forensic process. *It also demonstrates that...even the most distinguished expert can be wrong, but also provides a salutary warning against the possible dangers of an over-dogmatic expert approach.*
SIGNIFICANT ISSUE: CHANGE IN FOCUS

• Shift from ‘hunting guilty’ to ‘protecting innocent’.
• 179. ‘We recognise that justice may not be done in a small number of cases where in truth a mother has deliberately killed her baby without leaving any identifiable evidence of the crime. That is an undesirable result, which however avoids a worse one. *If murder cannot be proved, the conviction cannot be safe.*’

179 cont.

In a criminal case, it is simply not enough to be able to establish even a high probability of guilt. Unless we are sure of guilt the dreadful possibility always remains that a mother, already brutally scarred by the unexplained death or deaths of her babies, may find herself in prison for life for killing them when she should not be there at all. In our community, and in any civilised community, that is abhorrent.'
SIGNIFICANT ISSUE: REVIEW OF CRIMINAL CASES

• UK Attorney General Lord Goldsmith - immediate review of 258 criminal cases which increased to 297.
• Outcome: Approximately 1 in 8 to be reviewed (UK Attorney General media office)
• Report: Protocol for Care and Investigation of Sudden Unexpected Death in Infancy Sept 2004 Royal College of Pathologists and RCPCH
SIGNIFICANT ISSUE: REVIEW OF CIVIL CASES

• Review of civil cases has been highly controversial in UK. Estimated 5,000 cases needed to be considered (Hansard UK).

• **Review only of cases where disagreement between two expert opinions - this excluded many cases where experts such as Meadow appeared against no other expert.**

• **Local authorities undertook their own reviews, rather than an independent body.**

• Outcome: Only one case found in need of review!

• Problems in relation to compensation and re-unification of families
LM CASE

• LM was convicted of one count of torture and other counts of wounding and administering a toxic substance. Sentenced to 14 years (concurrent - to serve 7). Directly accused of ‘having’ MSBP/Factitious disorder by Proxy.
• She successfully appealed and was granted a re-trial.
• Review of further evidence led to the mother being offered an alternative to re-trial.
• Appeal judgement is binding on lower courts QLD and has persuasive value in other states (should relate to civil and criminal courts)
LM GROUNDS OF APPEAL

• The issue of allowing MSBP to be used in evidence.
• The issue of allowing commentary on video tape.
• Judicial error in redirection to jury.

The first and third upheld, the second partially upheld (check again)
LM SIGNIFICANT ISSUES: FINDINGS

- FDP (MSBP) does not relate to an organised or recognised reliable body of knowledge or experience. Evidence of psychiatrist and paediatricians using MSBP inadmissible - prejudicial rather than probative.
- Label is purely descriptive of a behaviour - no insight into guilt in a specific context.
- MSBP based on circular argument - presumption of guilt: How do you know she harmed the child? Because she has MSBP. How do you know she has MSBP? Because she harmed the child.
• R v Patel cited in [2004] EWHC 411 (Fam) Acquitted of murdering her three babies (under 3 months) by smothering/suffocation. Own grandmother in India found to have lost 5 babies for unexplained reasons.

QUESTIONS TO RAISE ABOUT FOLBIGG CASE

Prejudicial from beginning?
• Originally MSBP case
• Ophoven’s ‘Meadow’s Law’ in local court

Rejection of Similarity to Cannings Case:
• High Court rejected similarity to Cannings case on basis of evidentiary weight of diary entries.

Concerns:
• original trial contained multiple use of Meadow’s Law, even if statistics not specifically used
QUESTIONS TO RAISE ABOUT FOLBIGHG CASE

• The evidence of Dr Herdson, Berry and Beal was concerned with the issue that these 4 deaths were unprecedented and occurred for reasons not explicable by diagnosis. Dr Beal opined that he could not think of any natural cause which had not been excluded.

• The Cannings judgement specifically refers to the fact that just because we do not know why a child may have died, we cannot use the notion of exclusion to determine that it was the mother.

• Just because it is not recorded in the medical literature does not mean it has not happened - what about Patel’s grandmother? (5 children)
CIVIL CASE STUDIES

• Compilation case study
• A County Council and A Mother and A Father and X, Y, Z [2005] EWHC 31 (Fam)

Other Cases of Note:

• First Civil Case Review: Re LU and Re LB [2004] EWCA Civ 567
• D v East Berkshire Community NHS Trust, MAK v Dewsbury Healthcare NHS Trust, RK v Oldham NHS Trust
• P C and S v UK Government [2002] 2FLR 631 ECHR (NB cases from Netherlands, Finland and another UK case - see my ISPCAN paper 2004)
After three miscarriages, a male baby was born 6 weeks premature to a young mother. At eight weeks of age, the baby developed apnoea attacks and failure to thrive. The child was medicated for reflux and gastric problems and later underwent a fundoplication. The child developed serious vomiting, diarrhea and blacking out episodes. The child also appeared to be regressing and displaying behavioural difficulties. The mother presented with her arm in a sling to one appointment. The child developed a respiratory infection and was admitted to hospital. In hospital the child developed a bacterial infection.
This mother was accused of MSBP:

- causing her own miscarriages
- poisoning her child and withholding food
- exaggerating the child’s symptoms and her own.
- interacting badly with her child, who did not make proper eye contact with her
- presenting to hospital too frequently
- injecting bacteria into child to cause infection

All her children, except one, were removed from her care.
The miscarriages were caused by antiphospholipid antibodies in pregnancy.

No written evidence of any poisoning - one “verbal” report “positive” and one written report negative for poisoning - however, poisoning repeated as fact by multiple specialists in reports. Mother not at hospital on day poisoning supposed to occur.

Reflux made worse by Cisapride, as documented in hospital notes. Dosages above recommended levels. Cisapride now withdrawn from market for causing serious side-effects - compensation payments by Janssen Pharmaceuticals in US.
• Child actually gained weight in mother’s care, as noted in hospital files, but this was dismissed and files not consulted by specialists.
• Child’s breathing difficulties, regression and bowel problems occurred immediately after 8 week vaccination. Vaccination not given at corrected age for prematurity and given when child unwell.
• Child diagnosed with Asperger’s syndrome - reason for eye contact problem.
• Many ‘presentations’ to hospital were transfers from regional to city hospitals.
COMPILATION CASE STUDY - FURTHER FACTS

• Bowel difficulties and vomiting after surgery due to complications with 360 degree fundoplication and dumping syndrome - difficulties well documented in current medical literature - unknown to treating specialists.

• X-rays showing arm fracture never shown to court and therefore fabrication of this fracture repeated in medical summaries.

• The child developed haemophilus influenzae type B, despite vaccination, and related bacterial infection. Further infection after removal.

• Video surveillance showed no wrong-doing.
Justice Ryder concluded:

• Para 179: [child] Z was referred to different specialists with apparently true symptoms that included epilepsy, ataxia, and developmental delay. Mother over dramatised Z’s medical needs but it was not until the escalation of the precipitating circumstances that she was abusive to Z.

• Para 182: ‘This case should have been managed from at least 1999 by multi-disciplinary strategy meetings to which the parents should have been invited.’
SIGNIFICANCE OF UK HIGH COURT CASE

- Used R v LM as a precedent, dismissing use of MSBP/FII, despite the fact it was a civil proceedings, not criminal and in a foreign jurisdiction.

Justice Ryder stated in Para 174:

- ‘I take full account of the criminal law and foreign jurisdictional contexts of that decision but I am persuaded by the following argument upon its face that is as valid to the English law of evidence as applied to children proceedings.’
Justice Ryder stated, Para 178:

- ‘evidence as to the existence of MSBP or FII in any individual case is as likely to be evidence of mere propensity which would be inadmissible at the fact finding stage (see Re CB and JB supra). For my part, I would consign the label MSBP to the history books and however useful FII may apparently be to the child protection practitioner I would caution against its use other than as a factual description of a series of incidents or behaviours that should then be accurately set out’
• Highlighted concern about paper summaries without clinical consultation: Para 49:

‘Paper overviews can artificially limit the contextual material upon which opinion and in particular diagnostic opinion is given and can reduce the quality or cogency of the forensic expert’s opinion by his or her reliance on multiple hearsay.’
RE LU and RE LB [2004] EWCA Civ 567

• Whilst quashed on evidentiary grounds, warning by Justice Butler-Sloss to exercise caution in relation to:

• ‘the over-dogmatic expert, the expert whose reputation or amour propre is at stake or the expert who has developed a scientific prejudice’.
EUROPEAN COURT: MSBP CASE

P C and S v UK Government [2002] 2FLR 631 ECHR

* Removal of child at birth due to previous MSBP allegation:
Violation of Article 8 (Right to family life)

* Denial of legal representation:
Violation of Article 6, section 1 (Right to fair hearing)

* Faulty procedures concerning applications for care and freeing for adoption orders:
Violation of Article 8 (Right to Family Life)
CIVIL CASES: CHILDREN CAN SUE - WRONGFUL REMOVAL

- D v East Berkshire Community NHS Trust
- MAK v Dewsbury Healthcare NHS Trust
- RK v Oldham NHS Trust
- Three test cases heard before three judges headed by Lord Phillips, Court of Appeal for England and Wales. Public policy considerations barring claims in relation to wrongful diagnosis swept away by the Human Rights Act (October 2000). Authorities have a common law duty of care towards the children, even where the events predated the Human Rights Act.
SIGNIFICANT ISSUES

• The ruling will lay local councils and NHS trusts open to negligence claims dating back as far as 21 years, because the three year time limit for launching action starts to run only when a child reaches 18.

• This means a child may sue for wrongful removal from his/her family.

• However, court ruled it would be against public policy for parents to be able to sue for the harm they suffered as a result of their child's mistaken diagnosis.
A 6 year old boy was said by Professor David Southall of North Staffordshire Hospital to be a victim of fabricated illness. The boy's mother claimed that she suffered acute anxiety and depression as a result of the stress of dealing with the accusations against her. Her son was removed from the at-risk register after three months, when his condition was diagnosed as extensive and severe allergies.


BBC Real Life Program ‘Cherished’.


Daubert v Merrell Dow Pharmaceuticals 509 US 579 (1993)


General Medical Council, (2005), Fitness to Practise Panel (Professional Conduct) Transcript of Proceedings July 1, 4, and 5.


Pragnell (1998) `MSBP - a mythical malady’ - `Selective and Restricted Distribution for Professional Discussion'


www.gmc-uk.gov: June/August 2004 Fitness to Practise Decision: Prof David Southall

www.gmc-uk.gov: July 2005 Fitness to Practise Decision: Prof Sir Roy Meadow

www.gmc-uk.gov: July 2005 Fitness to Practise Decision: Dr Alan Williams