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- **Andrea Barnes** - Specialist Personal Injury & Clinical Negligence Barrister and Mediator (Normanton Chambers)

Please be aware: *Rules for expert evidence have changed since 2020 and it is recommended that all experts book an updating session to ensure they are compliant.*

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Welcome to the Medico-Legal Magazine

Welcome to Issue 33 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

In this bumper Conference issue of 2026, we have several articles from some of our speakers and sponsors, including Keynote, Andrea Barnes, Barrister, Normanton Chambers, covering the common pitfalls for experts; and articles from supporters MLKP, Expert Witness Gateway, and Premex. Other articles include:

Georgina Parkin, MD and Solicitor, Truth Legal, advising experts how to handle infant claims; and

Carolina Stamboulid, Scientific Evidence Analyst, Epistēmē Scientific Consulting, explaining breach vs causation; and

Nicola Witcombe, Independent Midwife, Mobile Midwives CIC, discussing the dangers of fragmented care in midwifery services; and

Linda Nelson, Barrister, Deka Chambers, detailing the growth in litigation involving weight-loss injections.

In our *Expert Witness Directory* we showcase more featured experts, who are available for instruction now.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It has a dedicated website www.medicolegalmagazine.co.uk and a page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed. Printed copies can be ordered from Iconic Media.

Specialistinfo maintains a database of contact details for up to 90,000 UK consultants and GPs, including approximately 11,000 consultants and GPs who undertake medico-legal work. We also provide Medico-Legal courses for expert witnesses and promote the members of the Faculty of Expert Witnesses (the FEW).

We welcome feedback from our readers, so please contact us with any suggestions for areas you would like to see covered in future issues or share your news and experiences with us.

Lisa Cheyne

Specialistinfo
Medico-Legal Magazine

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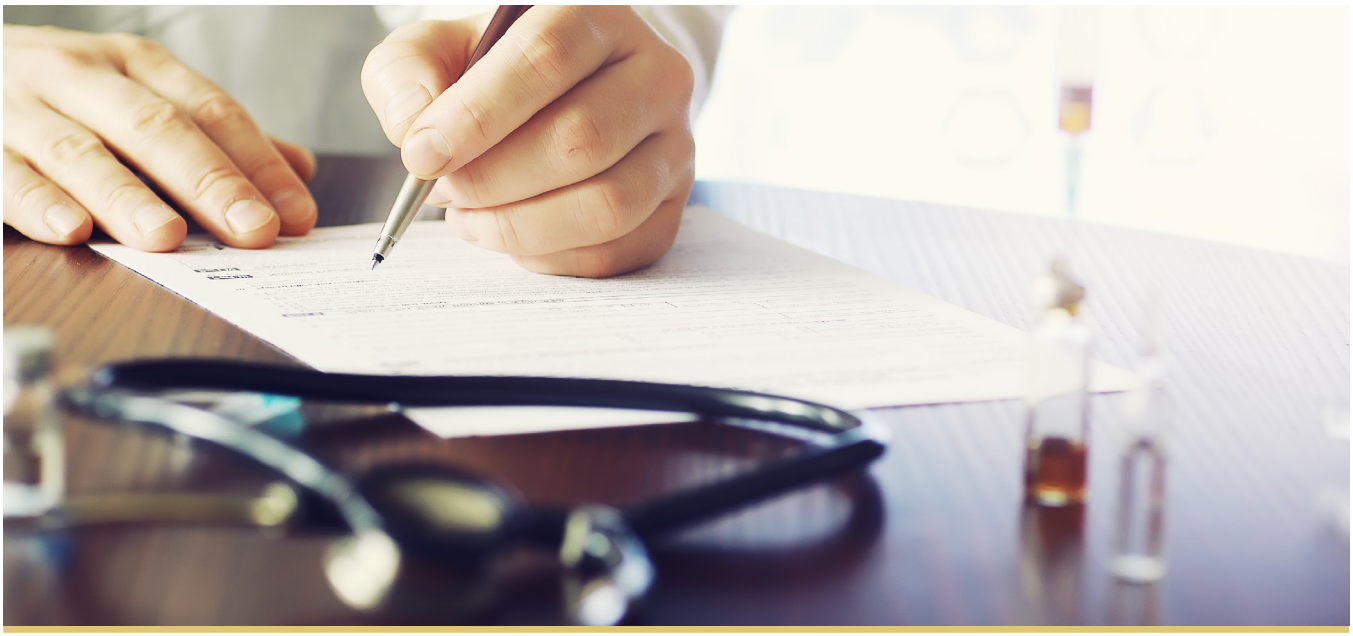

THE DIFFERENCE BETWEEN CLINICAL EXPERTISE AND EXPERT WITNESS EXPERTISE

By Mark Nicol, Director, Expert Witness Gateway

There is an important distinction between being an experienced clinician and being an effective expert witness. The two roles are related, but they are not the same.

Clinical expertise is built through training, practice and professional judgement. It allows a doctor to assess patients, interpret findings, make diagnoses and guide treatment. Expert witness expertise, however, requires something more. It requires the ability to take specialist knowledge and present it in a way that is clear, balanced and useful to those outside the clinical environment.

An expert witness is not simply there to provide a medical opinion in technical language. The role is to assist the court. That means offering an independent view, explaining the relevance of the medical evidence, and helping non-clinical readers understand both the strengths and the limits of that evidence. In many ways, the expert serves as a translation layer between the professional language of medicine and the everyday language used by lawyers, judges and others involved in legal proceedings.

That translation function is one of the most important features of expert witness work.

Complexities of terminologies

Medicine is full of terminology that is precise and meaningful within a clinical setting but can be difficult for others to follow. Doctors are used to communicating with one another in language that is efficient, technical and often highly condensed. A short phrase in a clinical note may carry a great deal of meaning to another clinician, but very little to someone without medical training.

This does not mean the terminology is wrong. On the contrary, technical language has an important purpose. It allows professionals to communicate accurately and quickly. The difficulty arises when that same language is transferred directly into a legal context without explanation.

Words and phrases that are entirely routine in medicine may be unfamiliar, or may be understood differently, by a non-medical audience. Even when a reader recognises a term, they may not appreciate its practical significance. A diagnosis, test result or clinical observation may sound highly important simply because it sounds complicated. Equally, something that appears minor in wording may in fact be very significant in practice.

The expert witness therefore has to do more than use the correct terminology. They have to interpret it. That means explaining not only what a term means, but what it means in context. Is it a routine finding or an unusual one? Is it likely to be central to the issues, or only one part of a larger picture? Does it support a strong conclusion, or is it something that must be approached with caution? These are the questions that matter outside medicine, and they cannot be answered by jargon alone.

Importance of language and good communication

This is where expert witness expertise becomes distinct from clinical expertise. The expert must be able to communicate complex ideas accurately, but also plainly.

Good expert communication is not about "dumbing down" medical knowledge. It is about making that knowledge accessible without losing precision. The aim is not to remove complexity where complexity genuinely exists, but to ensure that the complexity is explained rather than merely presented.

That requires careful use of language. A well-written expert report should not assume that the reader shares the author's medical background. It should guide the reader through the evidence in a structured and understandable way. Technical terms may still be necessary, but where they are used, they should be accompanied by a clear explanation. Opinions should be reasoned through step by step, rather than simply asserted.

Good communication also involves recognising uncertainty. In clinical practice, uncertainty is common. Doctors frequently work with incomplete information, evolving evidence and a range of possible interpretations. In expert witness work, that uncertainty must be expressed clearly and honestly. It is important to distinguish between what can be said with confidence, what is possible, and what cannot properly be concluded from the available material.

This clarity is essential because the audience for an expert opinion is rarely made up solely of clinicians. Legal professionals, parties to proceedings and the court must all be able to follow the opinion and understand how it has been reached. If the language is too dense, too academic or insufficiently explained, even a technically correct opinion may lose much of its value. A good expert does not simply know the medicine; they know how to make it understandable.

Best outcomes

The best outcomes are achieved when expert evidence is both clinically sound and clearly communicated. When an expert is able to translate specialist material into language that non-medical readers can properly grasp, the process becomes more effective for everyone involved. Lawyers are better able to identify the real issues. Judges are better equipped to weigh the evidence. Parties are more likely to understand the basis of the opinion. Most importantly, the court is better assisted.

This does not mean that expert evidence should become informal or over-simplified. The strength of the expert's role lies in combining professional depth with clarity of expression. Independence, accuracy and sound reasoning remain fundamental. But those qualities are most useful when they are conveyed in a way that others can genuinely engage with.

Ultimately, clinical expertise is the foundation. Expert witness expertise is what builds upon it. It is the skill of taking specialist knowledge, applying it to the questions that matter, and communicating it with fairness, discipline and clarity. In that sense, the expert witness is not only a medical specialist, but also an interpreter between two worlds. When that is done well, the result is evidence that is not only authoritative, but genuinely useful.

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WHEN MEDICAL EXPERTS GET IT WRONG

By Andrea Barnes, Barrister/Mediator, Normanton Chambers and Trust Mediation
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Andrea is a former Head of Chambers and a senior junior Barrister, with a distinguished legal career, in-depth forensic knowledge and exceptional advocacy to achieve success at trial. She specialises in clinical negligence, costs, personal injury, Coroner inquests and court protection litigation. She is an internationally accredited mediator, and a specialised conflict management and mediation trainer. She is the lead tutor for the SpecialistInfo Expert Witness training programme.

Under Civil Procedure Rule 35.2, an expert is defined as '*a person instructed to give or prepare expert evidence for the purposes of legal proceedings*.' Practice Direction 35, para 2.2 expands upon this definition, emphasising that an expert's overriding duty is to '*assist the court by providing objective, unbiased opinions within their area of expertise, and not to assume the role of an advocate*'.

This aligns with the legal definition of an expert as an individual who, through specialist training, study, or experience, is able to provide technical or professional opinion beyond the knowledge of the court (see Jackson and Powell on Professional Liability, Sweet and Maxwell, 9th Edition).

From a legal practitioner's perspective, the quality of expert evidence can determine whether a case is won or lost. From the court's perspective, the expert's role is to provide independent assistance on matters requiring specialist knowledge. This duty, enshrined in CPR 35.3, overrides any obligation to the party instructing or remunerating the expert.

Despite this clear framework, case law demonstrates repeated and persistent failures by experts to meet these standards, often resulting in judicial criticism, adverse costs orders, and, in some instances, contempt proceedings.

This article examines the principal reasons why medical experts fall short of their obligations.

Failing to Remain Independent

Independence lies at the heart of expert evidence. CPR 35.3 and Practice Direction 35 make clear that an expert must maintain objectivity and must not act as an advocate. A failure to do so is a fundamental breach of duty.

In *Jubair Ali v Caton & MIB* [2013], the defendant's neuropsychology expert was forced to withdraw or qualify a number of critical observations. The court found that the expert had lost objectivity after identifying perceived inconsistencies in the claimant's presentation. The judge stated:

> *'I have identified numerous occasions in the course of his cross-examination where Dr W was obliged to withdraw or qualify important and unjustifiable observations… Dr W lost the objectivity that is essential for a witness who is requested to provide independent expert evidence to the court"*

The Judge also criticised Dr W's use of emotive and partisan language, including describing opposing expert opinions as "cynical" and the claimant as 'failing' to commit to rehabilitation.

This case illustrates how easily an expert's evidence can be compromised where independence is lost, often irretrievably.

Inadequate Expertise and Unsupported Opinions

Courts are consistently critical of experts who stray beyond the limits of their expertise. In Jubair, Dr W was further criticised for questioning psychiatric evidence and expressing views on employability that lay outside his specialist competence. The Judge noted:

> *'this included his mistaken questioning in his May 2012 report of the validity of Dr B's (the claimant's psychiatrist) views about J's hearing of voices and his progressive hardening of view on the questions of whether J would have been able to obtain and maintain a career in the police force'.*

Similar criticism arose in ZZZ v Yeovil District Hospital NHS Foundation Trust [2019], where the claimant's orthopaedic spinal surgeon, Mr J, was found to lack the necessary expertise to comment on the injuries in question. The judge stated:

> *'The deficiencies in Mr J's evidence were both numerous and fundamental. First, I have grave doubts as to whether he has the expertise necessary to provide comments on injuries such as the present"*

In *Thimmaya v Lancashire NHS Foundation Trust* [2020], Mr J, faced further judicial censure, including an order for wasted costs with the court finding:

> *'Mr J was wholly unable to articulate the test to be applied in determining breach of duty in a clinical negligence case. He was given a number of opportunities to explain it; he was asked the questions in different ways; that did not assist him. In the end, he stated that he did not know the test to be applied.'*

In *Clark v Skyfire Insurance Limited* (2025), the Judge made numerous criticisms of two experts for the claimant; a counselling psychologist (referred in the judgment to as Dr A/Miss A and a physiotherapist (Miss K) stating:

*'It was abundantly clear that neither of the so-*called experts produced in this is a registered medical practitioner'…. 'Miss A is a counselling psychologist. She is not, and I emphasise the word not, a clinician. She is not a clinical psychologist.

The Judge criticised a number of Dr/Miss A's conclusions including:

> *'…there was no explanation by Dr A as to how she would divide up attribution… She merely boldly and baldly states 50/50. How she gets to it is impossible to understand.'*

With regard to Miss K, the Judge found:

> *'Miss K is not a doctor at all, as I understand it, and the consultation with Miss K took place over about 15 to 20 minutes. It was a remote one and no tests,*

of course, had been carried out or were carried out, by Miss K. Whether she could have carried some tests out or not, is not clear. She certainly did not carry out any test of any depth… I find her findings cannot possibly be relied upon. It is also odd in the extreme that Miss K entered into realms which were way beyond her expertise.'

He further criticised Miss K by stating:

"I found it literally unbelievable that over a 20 minute consultation over a handheld telephone with a camera on it she was able to assess a left shoulder movement as being 80 to 89 per cent of normal. She was given the chance to correct that by counsel for the defendant by suggesting it might be 80 to 90. No. She stuck rigidly to that. That is unbelievable at any level, quite frankly. It is spectacularly unbelievable when it comes to, as I have said, a 15 minute consultation over a telephone with a video recording on it"

The Judge concluded that Miss K's evidence '*was, I regret to say worse than useless*.'

The courts have repeatedly emphasised that expertise must be real, relevant, and demonstrable. Titles and experience alone are insufficient and a reasonable, logical explanation is required to support the proffered opinion.

Assuming Facts Without Proper Analysis

Practice Direction 35, para 2.3 requires experts 'to consider all material facts, including those which may detract from their opinions'. Failure to do so frequently results in judicial criticism.

In *Williams v Jervis* [2008], both the defendant's orthopaedic and neurology experts were criticised for prematurely concluding the claimant was malingering. The court found a lack of thoroughness and insufficient analysis of the evidence. The Judge held that:

'although Dr G has dealt with the claimant's case voluminously there are clear indications of a lack of thoroughness and a failure to spend adequate time in properly analysing the case'

Similarly, in Harris v Johnston [2016], the claimant's neurosurgical expert, Mr K, was found to have fundamentally misunderstood how the injury occurred. This mistaken assumption permeated his evidence. Despite being aware of the possibility of error, the expert failed to verify the factual basis of his opinion, constituting a breach of duty. The Judge stated that:

'Even if I were to be really generous to Mr K.. there was at least some confusion about what the instrument was, he was well aware of the possibility he had made a mistake… yet he did nothing to check if his assumption about the instrument used was correct. He was under a duty to have done so, and that he was in breach of that duty.'

Straying Beyond the Proper Limits of Expertise

Judicial concern about experts exceeding the scope of their competence is a recurring theme. In Squier v GMC [2016], an appeal from an MPT disciplinary hearing, the court upheld several findings regarding the clear limits of an expert's expertise stating:

'there is and can be no justified criticism of its [MPT] conclusions about the limits of Dr S's expertise.'

In *Jubair*, the Judge criticised the defendant's neurology expert, Dr W holding:

'Particularly damaging, in my view, was his willingness to enter into areas where he lacked any valid expertise.'

And in Clark, the courts reiterated that an expert's willingness to opine on matters beyond their specialist knowledge is particularly damaging to their credibility where the Judge concluded:

'Miss K has entered into realms beyond her expertise.'

Experts must be vigilant in identifying and respecting the boundaries of their expertise , where it falls outside their expertise they must either qualify, as they are required to do pursuant to Practice Direction 35, paragraph 3.2(8), the limitations or highlight which expert can determine that issue.

Assuming the Role of Advocate

Practice Direction 35.2 expressly prohibits experts from assuming an advocacy role. Expert evidence must be independent and uninfluenced by the pressures of litigation.

In *Muyepa v Ministry of Defence* [2022], the claimant's care and employment experts were criticised for producing partisan reports designed to maximise damages rather than provide balanced, objective opinions. The court stressed that experts are not part of either party's litigation team. The Judge stated, with reference to the claimant's employment expert:

> *'experts should constantly remind themselves through the litigation process that they are not part of the claimant's or defendant's "team" with their role being the securing and maximising, or avoiding or minimising, a claim for damages.'*

Failure to Comply with Rules and Guidance

Non compliance with procedural rules and expert guidance can have serious consequences.

The Supreme Court decision in *Jones v Kaney* [2011] marked a significant shift, confirming that experts are no longer immune from suit for breach of duty. Dr K's failure to comply properly with joint statement obligations highlighted the risks of procedural complacency. Dr K received judicial criticism for failing to read and simply signing a joint statement prepared by the defendant's psychiatric expert following CPR 35.12 discussions which contradicted her early held opinion.

In Williams, the conduct of the defendant's experts was found to fall "well below" acceptable standards, an application by the claimant for indemnity costs against them, with the Judge stating:

> *'Both these doctors, in their conduct as expert witnesses, justify in the Claimant's submission, an order for indemnity costs. Each was the subject of severe criticism in the main judgment. Their conduct, and the way they addressed their duties as expert witnesses fell well below what can properly be expected from expert witnesses and in my judgment can certainly be described as falling 'outside the norm.'*

More recently, in *Hamed v Ministry of Justice* (2024), the court criticised an expert for failing to:

1. disclose a copy of his instructions;
2. detail the range of professional opinion; and
3. provide details of relevant literature relied upon.

Despite signing a declaration of compliance, the expert demonstrated a fundamental lack of understanding of CPR Part 35. The report was described as "very weak" and non compliant. The judge stated:

> *"These are serious failings and it was clear from Mr D's evidence that he did not have an understanding of the requirements of Part 35, despite signing a declaration on 7 May 2021 that he was aware of the requirements of part 35 and practice direction 35... it is not sufficient for an expert giving an opinion upon which a court may rely, to simply state what his/her opinion is without justification for that opinion beyond that it is the expert's opinion that '...' on the balance of probabilities."*

Conclusion

The case law leaves little doubt as to the standards expected of medico legal experts. Independence, competence, procedural compliance, and methodological rigour are not optional; they are essential.

As the Judge observed in *Hamed*:

> *"I would urge Mr D to undertake some further training in expert medico-legal report writing to ensure that he fully understands the obligations of part 35 and his duties to the court."*

In the writer's opinion, initial training, ongoing education, and continuous professional development are critical to maintaining the integrity and value of medico legal expert evidence and I would recommend any medical practitioner venturing into the role of medico-legal expert does so. For further information please contact me or view the upcoming CPD courses available through SpecialistInfo:

https://www.specialistinfo.com/course-calendar-2026

THE ROLE OF A MEDICO-LEGAL EXPERT

By Dr Heidi Mounsey, Medical Protection, Medicolegal Consultant

Medico-legal experts are called upon in a diverse range of cases, including civil, criminal, coronial, and regulatory. While legal professionals are highly intelligent people, they may know little about the medicine and clinical practice under scrutiny in such matters. Medical expert opinion may therefore determine the course of an investigation, and has consequences for both patients and doctors. For patients and families, there may be distress and an unnecessarily lengthy process if an expert report leads to escalation of a case; and for doctors, adverse opinion may lead to the loss of their career or even liberty (for example, where gross negligence manslaughter is alleged).

It is therefore vital that there is a pool of medical experts to draw on for reasoned, comprehensive, and measured opinion, taking into account the expected and usual practice at the time in question, as well as appropriate guidelines and system pressures where relevant.

Sadly, however, finding good quality medical expert opinion can be difficult. The pool of experts is not as wide or diverse as it could be, and expert instruction often appears to rely on word of mouth.

There are a number of barriers to undertaking expert witness work, including time constraints, unfamiliarity with the legal and regulatory systems involved, and fear of criticism, which often means that experts are doctors towards the end of their careers, some of whom may no longer be in clinical practice.

It may be the case that there is a misconception of what constitutes an “expert” which leads to clinicians avoiding medicolegal work earlier in their careers, but doctors in active clinical practice are likely to be best placed to understand the current environment in which clinicians are working, and will hold up-to-date knowledge and technical skills. It could be argued that the majority of consultants and GPs should have the requisite clinical understanding to provide an expert opinion in their area of practice.

It can be difficult to combine the demands of the court timetable with busy clinical duties, but there are advantages to employers in supporting employees to participate in such work (albeit clinicians need to be very cautious that they are not undertaking private medicolegal work during NHS contracted time), such as development of the skills and experience to conduct patient safety incident investigations and root cause analyses.

Medical Protection would encourage doctors experienced in their field to feel empowered to undergo training in expert witness work and to put themselves forward.

At least some of the skills required to provide an expert opinion are similar to skills utilised in day to day clinical practice. The skillset for an expert witness includes the ability to understand and make sense of events through careful and detailed review of clinical records and other documents, and then explain the findings and interpretation in terms that an intelligent layperson can fully comprehend.

Additional skills include ensuring that the opinion does not comment on matters outside the field of expertise or qualifications, and holding firm if pushed to do so. It is important not only to be able to defend a view in a measured and assured manner, but to carefully listen to the arguments of others and give ground where necessary if presented with reasoned opposition. It should also be remembered that an expert witness is an independent advisor and must be unbiased in their analysis of the documents and the production of their opinion.

It is prudent to consider that, one day, appearance in court to be cross-examined may be necessary, and therefore ensure that any report and opinion would be able to stand up to such scrutiny.

One of the concerns about undertaking expert witness work is the possibility of being criticised – and this is indeed a risk. Should a report or oral evidence given in court be found to be substandard, there is the possibility of criticism or even legal proceedings for professional negligence to be brought against the clinician. The General Medical Council may also become involved in such matters, especially as there is a requirement for a doctor to self-refer in the event they are criticised by an official inquiry. This would include criticism in civil, criminal, and coronial proceedings. There is also the risk of referral by another party, including the instructing solicitor, in the event they are unhappy with the standard of the expert's work.

However, it is also important to recognise that clinicians already practise in a professional environment where scrutiny, complaints, and the possibility of criticism are familiar. As with clinical practice, doctors carrying out expert witness work should ensure they have appropriate professional indemnity in place. Medical defence organisations provide members with the right to request advice and support when medicolegal concerns arise, including access to specialist medicolegal advisers and legal representation where appropriate.

Medical Protection case study

Medical Protection assisted with one such case where Mr F, a hepatobiliary surgeon (instructed by the Claimant's solicitors) was heavily criticised by the Judge in a clinical negligence claim with respect to whether there had been an unacceptable delay in performing a cholecystectomy for the Claimant following an episode of severe cholecystitis, which had occurred during the time of the covid pandemic. Mr F considered that there had been an unacceptable delay, but at this point had not been in any clinical practice for over eight years, and had last worked exclusively in private practice. It became clear in his evidence that he was not aware of the limitations of NHS resources, especially at the time of a pandemic, nor of the local policies of the Trust (which had formed part of the initial bundle of material provided to him), and he became impatient and argumentative with the Defendant's barrister when questioned on this.

The Claimant's clinical negligence claim failed and Mr F contacted Medical Protection, concerned about the criticism levelled at him by the Judge. The matter was carefully reviewed by a medicolegal consultant and legal advisor, and it was concluded that this was a matter which met the threshold for self-referral to the GMC. Mr F was then assisted in drafting a self-referral to set out the facts of the case. The Claimant, in the meantime, also referred Mr F to the GMC,

alleging his report and evidence in court had been substandard and that he was not fit to practise in the medicolegal arena.

The GMC investigated the matter, and obtained their own expert opinion, which considered that Mr F had fallen short in his role as an expert witness, and concluded that both his report and the evidence he provided in court were below the standard that would be expected.

The GMC progressed the case to the Rule 7 stage, where Mr F was presented with a list of formal allegations to address. Mr F met with his medicolegal consultant and legal advisor to discuss the allegations in detail, and compile a response. Most of the allegations were admitted, including that Mr F had not read the material provided to him in sufficient detail as to conduct an objective analysis, and had stepped outside his area of knowledge and expertise in providing a view on what was a reasonable timeframe for management of the patient in the NHS setting and during the covid pandemic. By this time, Mr F had undergone additional training in expert witness work, and had also extensively reflected on the matter. With support from Medical Protection, he was able to provide the GMC with evidence of his further training, ongoing CPD, and a detailed and thoughtful document acknowledging the errors he had made and the impact of these on the Claimant and the other parties involved in the claim.

The matter was passed to the case examiners for a decision on disposal of the case, and they concluded that, due to the extensive remediation Mr F had demonstrated, the matter could be ended by way of a warning, rather than a referral to a Medical Practitioners Tribunal.

While this serves as a cautionary tale, an expert is unlikely to attract much in the way of trouble or criticism if they are mindful of their obligations, some of which are discussed above, and hold appropriate indemnity for this work.

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DELAYED DIAGNOSIS CASES: BREACH VS CAUSATION

WHY POPULATION EVIDENCE DOESN'T AUTOMATICALLY ANSWER INDIVIDUAL CAUSATION QUESTIONS

By Dr. Carolina Stamboulid, BSc, PhD, Scientific Evidence Analyst and Founder of Epistēmē Scientific Consulting
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Dr. Carolina Stamboulid is a scientific evidence analyst specialising in the interpretation of medical research in legal and insurance contexts. With a PhD in biomedical research from the University of Manchester and ongoing postgraduate studies in Medical Law and Ethics at the University of London, she provides independent analysis of how research evidence functions when applied to individual cases. She founded Epistēmē Scientific Consulting to help legal and healthcare professionals navigate the methodological complexities of scientific evidence.

In delayed diagnosis claims, two questions typically sit at the centre of the case: Was there a breach of duty? Did that breach cause the eventual harm?

The first question, whether there was a breach of duty, often has clearer reference points. Clinical guidelines, referral pathways and expected standards of care provide a framework for assessing whether particular actions should have been taken, though applying them to specific circumstances still requires judgement.

Causation, however, requires demonstrating a link between the breach and the harm. This is where population-level research, while robust, does not always answer the individual causation questions delayed diagnosis cases require.

This is the methodological problem at the heart of many delayed diagnosis cases.

The problem with "earlier is better"

A large body of research shows that earlier diagnosis of conditions such as cancer is associated with better survival at a population level. This is robust, widely accepted, and often cited. But population-level truth does not automatically translate into individual-level certainty.

These studies tell us what tends to happen across thousands of patients. They do not necessarily tell us what would have happened for one particular person had their scan, referral, or follow-up occurred earlier. In this gap, scientific evidence can become unintentionally over-interpreted in litigation.

Why we can't simply extrapolate to one person

Most of these studies are observational, large-scale, and designed to detect patterns across populations. They are not designed to answer the counterfactual question at the heart of causation analysis: "*What would have happened to this patient if the diagnosis had been made earlier?*"

There are several scientific reasons why this leap is unsafe.

First, earlier detection can create lead-time bias, where survival appears longer simply because the clock started sooner, not because the patient actually lived longer. Second, cancers behave very differently from one another. Some are aggressive from the outset. Others are slow growing. Population data averages these behaviours, but an individual patient experiences only one of them. Third, these studies show association across thousands of cases; they do not prove that delay caused the outcome in a specific case. Finally, study design cannot account for all the variables that influence how far a disease had already progressed at the moment the alleged breach occurred.

While the research clearly supports the general principle that earlier is better, it does not automatically answer the legal question of whether an earlier referral or scan would have changed the outcome for this particular person. That is where evidence is often asked to go further than it was ever designed to go.

What over-interpretation looks like

Over-interpretation happens when population statistics are used to answer an individual counterfactual question. When association is treated as proof of causation for one person. When study design limitations are overlooked. When complex disease behaviour is reduced to a simple linear assumption.

A useful way to think about this is through an analogy.

Imagine a study shows that people who leave their house earlier in the morning are much less likely to be caught in traffic and arrive late to work. That finding is robust across thousands of commuters. But if one person leaves at 7am and still arrives late, you can't automatically say: "*If you had left at 6:30am, you would definitely have arrived on time.*"

Because on that particular morning there may have been an accident, roadworks, a closure, or unusually heavy congestion. The population data tells us what *usually* happens. It doesn't tell us what would have happened on that specific journey on that specific day.

Delayed diagnosis evidence works in the same way.

Research shows that, overall, earlier diagnosis is associated with better outcomes. But for one patient, the "traffic conditions" - tumour biology, growth rate, stage at the time of the breach - may mean the outcome was already largely determined. The general pattern is true. The individual counterfactual is still uncertain.

Why this matters in practice

In these cases, both sides may rely on the same body of research. The data itself is not disputed. What differs is the question being asked of it. One side may

use the research to argue that earlier diagnosis would have changed the outcome. The other may argue that the evidence cannot support that conclusion with certainty for this individual.

The science has not changed. The interpretation has.

This matters because not all population evidence fits all individual cases equally well. The studies underpinning "earlier is better" have specific inclusion and exclusion criteria. They may exclude patients with certain comorbidities, particular disease subtypes, or specific demographic characteristics. The effect sizes reported are averages across heterogeneous populations. The time intervals studied may not match the delay in question.

When these methodological details are examined closely - what populations were actually studied, what outcomes were measured, how the data was analysed - it becomes clear whether the evidence genuinely supports a causation conclusion for this patient, or whether it is being asked to stretch beyond what the study design can reliably demonstrate.

When causation can be demonstrated

Understanding these methodological boundaries doesn't make causation impossible to prove. It makes causation arguments more robust when they can be proven.

Courts have examined these issues in practice. In *De Francisci v Hampshire Hospitals NHS FT* (2024), the court considered the type of evidence experts relied upon when population research was used to answer individual causation questions, including the distinction between aggregate data and individual participant data meta-analyses.

This was an obstetric HELLP syndrome case, where breach was admitted but causation failed, reducing a claim valued at ~£430,000 to ~£11,500 after the court stress-tested the medical literature behind the expert opinions.

The court didn't reject the science, but it found that the studies being relied upon couldn't safely bear the weight of the conclusion placed on them. This reflects a broader principle: when evidence quality is scrutinised, the strength of the underlying methodology becomes central.

When population evidence is strong and the individual case facts align with it - the time intervals fit, the disease behaviour matches the study populations, the biological plausibility is sound - then causation can be demonstrated more confidently.

The problem arises when those conditions don't align. When the delay was short but the disease aggressive. When the patient had characteristics excluded from key studies. When confidence intervals are wide or study designs observational. In these situations, being clear about evidential limits prevents both sides from overstating what the research can prove.

This isn't about raising the bar impossibly high. It's about asking: does this evidence, in this case, genuinely support the causation conclusion being drawn? Sometimes it does. Sometimes it doesn't. The methodological framework helps distinguish between the two.

How to approach this more safely

The way around this is not to dismiss the research, but to ask it better questions.

Instead of asking: *"Does evidence show earlier diagnosis improves survival?"*

Ask: *"Does this evidence allow us to say that earlier diagnosis would likely have changed the outcome for this patient, given what we know about their disease at the time?"*

That shift changes everything. It means looking at the behaviour of that disease type, the time interval between breach and diagnosis, whether progression within that timeframe is biologically plausible, and what the cited studies were actually designed to measure. This brings the question back from population averages to individual plausibility.

Understanding where population evidence legitimately stops, and where case-specific analysis must begin, makes causation arguments more precise and decisions ultimately fairer.

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WEIGHT-LOSS INJECTIONS: GROWTH IN LITIGATION LIKELY, AS WAISTBANDS SHRINK

By Linda Nelson, Barrister, Deka Chambers, London

Linda is a barrister with a specialist clinical negligence and personal injury practice. Her clinical negligence practice encompasses spine and brain injuries, catastrophic injuries including loss of limbs, delayed diagnoses and birth injuries. She has a strong focus on cross-border claims, both in her personal injury and Admiralty work and in her clinical negligence work. She is a contributing author of 'Clinical Negligence Claims: A Practical Guide'.

In recent years, weight-loss drugs have revolutionised the diet industry. The brand names Ozempic, Wegovy, and Mounjaro have become part of the common lexicon and an estimated 1.5 million people in the UK now use these drugs[1].

Ozempic is a prescribed medication for Type 2 diabetes, and Wegovy is prescribed specifically for management of obesity. Both contain the same active ingredient, semaglutide. The active ingredient in Mounjaro is tirzepatide: both those ingredients work by mimicking the hormone GLP-1 (glucagon-like peptide-1), which suppresses the appetite and gives a feeling of satiety.

Approximately 1 in 8 adults (12.5%) in America were using GLP-1 injections in November 2025[2] and such is the efficacy of the drugs that the effects are being seen in many aspects of society. In May 2025 *Weight Watchers* filed for bankruptcy in America and cited the rapid rise in popularity of GLP-1 weight-loss drugs as a key factor in its financial struggles. Its troubles were already evident in 2024, when Oprah Winfrey announced that she was leaving its board, having already revealed that she uses weight-loss drugs as a "maintenance tool."[3] In the UK, restaurants are offering smaller portion sizes to cater for diners using the injections, with Heston Blumenthal (who also uses them) developing a taster menu for that reason[4]. Tailors have reported a 20% increase in business, with clients spending on new suits or alterations to existing clothing[5].

The injections are prescription-only medicines and therefore can only be prescribed by an 'appropriate practitioner',[6] namely a doctor, dentist, 'supplementary prescriber', nurse independent prescriber or pharmacist independent prescriber. The NHS prescribes the medications where the patient meets certain criteria. In December 2024 NICE published a Technical Appraisal[7] recommending Mounjaro as a treatment option for adults with a BMI (body mass index) of at least 35kg/m2 (less for people from certain backgrounds, e.g. Asian) and with at least one weight-related health condition (e.g. high blood pressure). NHS prescription is carefully controlled: NHS guidelines state that patients should follow a diet and physical activity programme, and the drug can only be prescribed for a

maximum of two years[8]. The Technical Appraisal and the MHRA (Medicines and Healthcare Products Regulatory Agency) confirm that structured wraparound care is a required treatment component: clinical support (including eligibility assessment, safe prescribing, dose management and referral to other clinicians where appropriate) and behavioural support (including advice and support with nutrition and acknowledging obesity as a chronic, relapsing condition shaped by biology, environment and psychology)[9]. NHS prescriptions can be issued by specialist weight management services on referral from a GP and, since June 2025, by primary health care providers (e.g. GPs).

Known side effects of the medications include nausea, stomach pain, vomiting, diarrhoea and unplanned babies (Mounjaro can inhibit the absorption of the contraceptive pill, so additional methods of contraception are needed). Patients who fail to ensure their body's nutritional needs are met can experience hair loss, a common side effect of Mounjaro, affecting up to 10% of people[10]), and muscle loss. Additionally, when the patient stops taking the drugs, they will regain the lost weight if they have not made the necessary changes to their diet and exercise habits. It is therefore important to counsel prospective users of the injections on such points, to ensure that prescription is appropriate for them, and to provide the wrap-around care specified by the MHRA.

Many people who do not want to wait for an NHS prescription, or who do not meet the NHS prescribing criteria, legitimately obtain the injections on private prescriptions issued by independent prescribers (e.g. nurses, and pharmacists) and regulated online services (e.g. Boots/Asda Online Doctor). The GPhC (General Pharmaceutical Council: a statutory body and the independent regulator for pharmacists in Great Britain) tightened the rules for online weight-loss drug sales in 2025, introducing stricter requirements in respect of assessment of patient BMI and medical history. Regulated online pharmacies can no longer rely solely on simple questionnaires and must instead independently verify a patient's weight and BMI e.g. via video consultations. Such regulation is required to protect people seeking prescriptions inappropriately (e.g. people with eating disorders).

In the UK, more than 90% of people are believed to pay privately[11], and with private prescriptions costing hundreds of pounds per month, inevitably there is a growing and flourishing black market. Regulation 214(1) of the Human Medicines Regulations provides that '*a person may not sell or supply a prescription only medicine except in accordance with a prescription given by an appropriate practitioner*'. Despite this, products sold as weight-loss injections are readily available without a prescription online, advertised on social media, and in beauty salons on the high street[12]. The MHRA works to shut down such websites and social media accounts, but faces the 'whack a mole' problem of rampant proliferation. Unlicensed versions of the drugs present a health lottery to the user and can contain toxic ingredients. Obviously, any such medication would fall foul of the Consumer Rights Act 2015 requirement that products be of satisfactory quality. Users of unlicensed products will not benefit from the protection afforded to users of licensed products, which are subject to regulation and authorisation by the MHRA and must comply with the internationally recognised Good Manufacturing Practice (GMP) standards enforced by the MHRA, which cover various aspects of manufacturing and compliance verified through regular inspections.

America has already seen numerous product liability lawsuits filed against Eli Lilly and Novo Nordisk (manufacturers of the weight-loss drugs), for failing to adequately warn of severe side-effects. There is also the potential for issuing clinical negligence claims against authorised prescribers, for issuing prescriptions inappropriately (e.g. failing to follow requirements in relation to initial patient assessments or failing to follow new guidance of which they should have been aware) or for failing to ensure the patient is fully advised of the associated risks and need for wraparound care. So too will claims lie against sellers/manufacturers of unlicenced medicines/injections without prescription, but in such cases identification of a defendant with funds/insurance is likely to be an issue.

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PARALLEL SERVICES, FRAGMENTED CARE: WHY THE NHS MUST ENGAGE WITH INDEPENDENT MATERNITY PROVIDERS

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Mobile Midwives CIC offers independent support and guidance, working alongside existing maternity services to help women access safe, informed and coordinated care throughout pregnancy and beyond.

Over the past decade, the landscape of maternity support in the UK has quietly begun to change. Alongside NHS maternity services, a growing number of independent and specialist providers have emerged: private scan clinics, specialist treatment services for conditions such as hyperemesis gravidarum, independent midwives, and educational or support services run by experienced clinicians. Many of these professionals have worked within the NHS and remain bound by the same professional codes, regulatory standards, and safeguarding responsibilities.

Women are increasingly accessing these services not as replacements for NHS care, but as supplements to it. In many cases, they are attempting to bridge gaps in stretched services — seeking reassurance, clearer information, or more timely support when the system struggles to meet demand. The result is a mixed maternity ecosystem in which women may interact with multiple providers during the course of a single pregnancy.

However, while this parallel network of services has grown, the structures that govern communication and safeguarding have not evolved at the same pace. Independent providers who attempt to establish clear routes for raising concerns or sharing safeguarding information may encounter institutional resistance, with some NHS organisations taking the position that they do not engage with private services. While such responses may reflect understandable concerns about boundaries and governance, they also reveal a structural blind spot: organisational separation is being mistaken for professional independence.

When multiple services interact with the same women and families, refusing professional dialogue does not eliminate the interface between them — it simply makes that interface less visible and potentially less safe. Safeguarding responsibilities do not disappear at organisational boundaries, and neither do the vulnerabilities of the women receiving care.

Understanding the Wider Context

The growing use of independent maternity services must also be understood within the broader context of pressure on NHS provision. Many services have seen reductions in antenatal education, postnatal support, and continuity of care. Women may enter subsequent pregnancies already carrying the impact of previous difficult or traumatic experiences, and increasingly seek out additional sources of support to help them navigate their care.

The Royal College of Midwives has highlighted the importance of structured "birth conversations" in supporting women to process their experiences and make informed decisions in future pregnancies. However, provision of this support remains inconsistent, and in many areas insufficiently resourced.[1,5]

In the absence of accessible, consistent support, women may turn to alternative sources of information — including online platforms, newly emerging digital tools, and communities that vary significantly in quality and reliability. While some of these spaces offer connection and reassurance, others may lack clinical grounding, increasing the risk that women are navigating complex decisions without balanced or evidence-based support.

Fragmentation, Safeguarding and System Risk

The risks associated with fragmented care are not new. High-profile safeguarding cases such as those of Victoria Climbié and Baby P demonstrated the consequences of poor communication and lack of coordination between services. In maternity care, similar patterns can emerge when information is not effectively shared across professional boundaries.

Recent national reporting reinforces that these risks remain current. Inspections by the Care Quality Commission between 2022 and 2024 found that nearly half of maternity services in England were rated as requiring improvement or inadequate. Recurrent themes include failures in communication, concerns not being listened to, and organisational cultures that inhibit escalation.[2] The General Medical Council has also reported that over a quarter of obstetrics and gynaecology trainees feel hesitant to escalate concerns, highlighting ongoing challenges in safety culture.

Findings from major maternity inquiries further reinforce these themes. The Ockenden Review[3] identified repeated failures to escalate concerns, poor multidisciplinary communication, and a culture in which staff felt unable or unsupported to raise issues. In many cases, concerns were either not acted upon or were insufficiently integrated into care planning, with missed opportunities for intervention leading to avoidable harm.

National data also highlights that the women most at risk of poor outcomes are often those facing multiple disadvantage, including socioeconomic deprivation and mental health challenges. Findings from MBRRACE-UK continue to demonstrate significant inequalities in maternal outcomes across the UK.[4] These are not typically the groups most likely to access independent or private services. However, as alternative models of support become more visible and accessible, this may begin to shift.

In this context, it becomes even more important that concerns identified by any professional — regardless of organisational setting — are recognised and appropriately acted upon. Where safeguarding failures have historically occurred, they have often done so despite concerns being raised within systems. Choosing not to engage with information from external providers risks recreating those same conditions, where early opportunities to intervene are missed.

Medico-Legal Implications of Fragmented Care

Fragmentation has practical implications for both clinical safety and legal accountability.

Firstly, safeguarding concerns may not be shared effectively. Independent providers, like their NHS counterparts, are bound by professional and legal responsibilities to raise concerns where appropriate. However, without recognised routes for information sharing or escalation, opportunities to intervene early may be missed.

Secondly, clinical information becomes fragmented. Women may receive advice, monitoring, or reassurance from multiple sources, but without coordination, no single professional holds a complete picture of their care. This increases the risk of inconsistency, duplication, or gaps in decision-making — particularly in complex or high-risk pregnancies.

Thirdly, responsibility can become blurred. When outcomes are reviewed, questions may arise around who was responsible for recognising deterioration, advising escalation, or acting on emerging concerns. In a system where communication pathways are unclear, accountability becomes more difficult to define — particularly where concerns raised in one setting are not acted upon in another.

From a medico-legal perspective, this creates a significant challenge. Risk is no longer confined to the actions of an individual professional, but emerges from the spaces between services — where information is not shared, concerns are not heard, and systems do not align.

It is important to be clear: the existence of independent or parallel services is not inherently unsafe. However, a lack of structured engagement between those services and NHS care introduces avoidable risk.

What Needs to Change

If maternity care is to reflect how women are now accessing support, then the system must evolve accordingly.

NHS trusts are, and should remain, the central coordinators of maternity care. However, coordination cannot exist in isolation from the wider network of care that women are already engaging with. Where multiple providers are involved, safe care depends not on separation, but on structured collaboration.

At present, independent and private providers are often positioned as external to the system — tolerated at best, and at times viewed as a potential liability. This creates a dynamic that is unhelpful for both professionals and the women they serve. A shift is needed from a model of exclusion to one of accountable inclusion.

This includes the development of clearer pathways for communication, escalation and information sharing between NHS services and independent practitioners. It also requires consideration of how independent providers are recognised and governed within the wider system. Strengthening revalidation processes for practitioners working outside the NHS, alongside exploring more consistent indemnity frameworks, may help to reduce the perceived divide between sectors and support a more unified standard of care.

There must also be space for more open and nuanced conversations about choice. Women may, at times, make decisions that sit outside of standard guidance, particularly where previous experiences of care have been difficult or traumatic. When supported appropriately, this does not inherently equate to unsafe care. However, without professional engagement, these situations risk becoming polarised, leaving women navigating complex decisions without consistent or coordinated support.

In some cases, women may disengage from NHS services altogether when they feel their choices are not recognised or supported. This further increases the risk of fragmented care, as opportunities for shared decision-making and ongoing monitoring are lost.

To address this, there must be greater scope for direct professional dialogue between NHS teams and independent practitioners. In particular, creating space for collaborative conversations between consultant obstetricians and independent professionals may help bridge gaps in perspective and support more cohesive care planning. While different professional roles may approach risk, physiology and intervention from distinct angles, these perspectives are complementary when brought together effectively.

Finally, it is important to recognise that the growth of independent maternity services is not occurring in a vacuum. In some cases, these services are meeting

needs that the current system, under significant pressure, is struggling to provide — including time for discussion, continuity, and personalised support.

Conclusion

Ultimately, the future of safe maternity care will not be defined by whether services sit within or outside of the NHS, but by how effectively they work together around the needs of women and families. A system that is able to recognise multiple sources of support, communicate openly, and respond proportionately to risk is one that is better equipped to prevent harm, not just react to it.

Rebuilding trust in maternity services will require more than structural reform; it will require a cultural shift towards collaboration, respect for professional contribution across settings, and a renewed focus on informed, person-centred care. When women feel heard, supported and able to make decisions about their care within a connected system, safety is strengthened — not compromised.

The challenge now is whether maternity services can evolve to meet this reality, or whether fragmentation will continue to grow in the spaces where collaboration has yet to be established.

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INFANT CLAIMS: ETHICS, CAPACITY AND THE EXPERT WITNESS

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Georgina is a Solicitor with over 16 years of experience in personal injury litigation and has acted for injured Claimants in a variety of cases including accidents and assaults at work, road traffic accidents, public liability, product liability and clinical negligence. She has a particular interest in chronic pain disorders and serious injury cases. She has provided training to doctors wanting to become expert witnesses and to improve their medico-legal practice. She has spoken at personal injury and medico-legal conferences.

Infant personal injury claims are often emotionally charged and ethically complex. In the context of this article and litigation generally, the term 'infant' refers to any child under the age of 18. Infant claims require expert witnesses to navigate not only technical medical questions, but also the heightened emotional context in which those opinions are formed. Such claims may involve injuries of a life-changing nature, where long-term outcomes are uncertain and the evidential landscape is incomplete, especially in the early stages of proceedings.

Over the past 16 years, I've worked with clients of all ages. However, some of the most challenging cases on which I have been instructed, are those where I have acted on behalf of babies or toddlers with catastrophic burn injuries. These cases present unique challenges because, particularly in the early stages of a claim, the injured party cannot contribute meaningfully to the factual account of what has occurred or how their injuries impact their day-to-day life. The lack of direct evidence places increased reliance on secondary sources and heightens the importance of careful, methodical analysis by both solicitors and experts.

As the mother of two children aged five and under, the emotional weight of these cases is impossible to ignore. It is difficult to not put myself in the position of the parents; fearful, desperate for answers, and striving to do what is best for their child. While empathy is an important professional quality, my role as their child's solicitor and the role of the expert witness, requires something more than empathy: it requires clarity, independence, and a grounding in objective evidence.

This article explores the ethical, emotional, and practical challenges medico-legal experts face in infant claims, with emphasis on the duties imposed on experts under CPR 35, and the importance of clarity in medico-legal evidence when solicitors are preparing for infant approval hearings.

Capacity and Evidential Reliance in Infant Claims

A key distinction arises when comparing babies, toddlers and primary school age children with older children.

Where a child demonstrates sufficient maturity and understanding, often from early adolescence, they may be regarded as being Gillick competent, meaning they possess the intelligence and understanding required to appreciate what is involved in their treatment. In practice, where a child is aged 12 or over (in some cases younger), they are often able to provide their own account of:

- the nature of their injuries
- ongoing symptoms
- psychological impact
- anticipated long-term effects

This evidence can materially assist in shaping prognosis.

By contrast, babies, toddlers and other younger children are unable to, or are limited in providing any such account. Their experience must be interpreted through others, most commonly parents or guardians acting as litigation friends. This introduces an additional layer of interpretation, requiring experts to critically assess not only what is being said, but how and why it is being conveyed.

When a child cannot participate meaningfully in an assessment, experts must adapt their methodology. This may involve:

- parental accounts provided at the appointment and perhaps also in the form of a witness statement
- working closely with parents and any other caregivers to understand daily functioning of the infant
- conducting assessments in the child's home or familiar surroundings
- reviewing medical records
- considering imaging and clinical photography
- evaluating therapy and rehabilitation records.

While these adaptations can help build a fuller picture, they also bring a level of emotional impact. Going into a family home where dressings, feeding equipment, or mobility aids are present can be genuinely affecting. It is important for experts to be aware of their own emotional responses and ensure these do not influence their clinical analysis. In practice, this requires a heightened level of professional discipline, particularly where the injuries observed are severe or life changing.

The Role of the Litigation Friend and Evidential Consistency

The litigation friend plays a central role in infant claims, particularly in providing:

- the factual narrative of the accident
- detail regarding treatment and recovery
- insight into the day-to-day impact of the injuries on the child's life.

Parental accounts will not always align with the contemporaneous medical records. This is neither

unusual, nor itself, indicative of unreliability. In my experience handling serious and sensitive personal injury cases, I have seen how genuine memories can fade, blur or become unintentionally reshaped by later conversations, medical appointments, or the stress of ongoing litigation. Most litigation friends are also not medically trained and may have limited understanding of the treatment received by their child.

The expert's task is not to treat every discrepancy as significant, but to evaluate whether any inconsistency materially affects the reliability of the overall clinical picture. Where a clear conflict arises between the account provided and the objective medical evidence, particularly in relation to the mechanism of injury, the location of injury, or the nature and timing of treatment; this should be identified and addressed within the report.

Equally, experts should exercise caution not to overemphasise minor differences in recollection that do not materially affect their opinion. The focus should remain on producing a balanced, evidence-based assessment that reflects the totality of the available material, rather than elevating immaterial discrepancies into forensic issues.

CPR 35: The Structure That Safeguards Impartiality

Under CPR 35.3, the expert's primary duty is to the court. This duty overrides any obligation to their instructing solicitor, or the infant examined for the purpose of the report.

In practical terms, experts are required to:

- provide independent and unbiased evidence
- distinguish between fact, assumption and opinion
- identify limitations in their expertise
- consider alternative explanations
- remain within their field of competence.

In infant claims, where the evidential picture is indirect and often emotionally charged, adherence to the above principles is critical. Failure to do so can undermine not only the expert's opinion but also the court's ability to rely upon evidence as a whole.

Managing Emotional Exposure and Maintaining Objectivity

Infant personal injury claims often involve difficult material: clinical photographs, medical records, and detailed accounts of trauma.

Experts need to approach this work with compassion: communicating sensitively, acknowledging distress, and helping parents or guardians understand the process. However, compassion shouldn't slip into advocacy. It is important that experts avoid:

- softening conclusions to spare parental feelings
- leaving out uncertainties in an attempt to reassure
- presenting assumptions as facts
- framing their opinion around what they believe the litigation outcome should be.

The integrity of the infant approval process, and the fairness of the child's compensation, relies on experts remaining objective. That requires ongoing self awareness and, at times, a willingness to step back and critically reflect on one's own reasoning and potential biases.

In practice, helpful preparation strategies for medico legal appointments involving infants can include:

- reviewing records and evidence in advance, so the expert knows the key events and treatment received before meeting the parent or guardian
- preparing a clear structure for the appointment or interview
- avoiding multiple infant medico legal appointments on the same day
- allowing space between appointments to reset
- dictating notes immediately afterwards.

These steps support independent analysis and reduce the risk of emotional carryover between cases, a real challenge in work of this nature.

What Makes a Good Medico-Legal Report in Infant Claims

There is relatively little judicial commentary in personal injury cases on this issue.

Speaking from my own experience and what I look for when reviewing reports, a good medico-legal report should be strictly necessary to the issues in dispute. It should be focused, targeted, and avoid duplication, concentrating only on matters that assist the court in reaching a decision. The analysis should be clear and directly relevant, rather than generalised or descriptive.

High-quality reports will also share several key features. They should be:

- Well researched
- Grounded in sound clinical or scientific evidence
- Clear, structured, and easy for the court to follow
- Open and candid about uncertainties, limitations, and differing opinions
- Balanced and impartial, avoiding overly defensive or absolute conclusions

Overall, the best reports assist the court by providing clear, objective, and well-reasoned opinions, while acknowledging where there is genuine uncertainty.

Infant Approval Hearings: Why Clear Expert Evidence Is Crucial

Infant settlements are subject to court approval. This safeguard ensures that a vulnerable claimant, who cannot evaluate their own best interests, receives fair compensation. These hearings are not procedural formalities. Judges scrutinise the evidence very carefully.

For approval of the settlement to be granted, expert evidence must be:

- clear
- final
- definitive where possible
- free from uncertainty.

A clear and reasoned prognosis is fundamental in infant claims. If an expert expresses uncertainty regarding a prognosis, long-term impact, psychological outcome, the scope and timeline for recommended treatment, or scarring progression, the court will not approve the settlement.

This is why experts must clearly state within their CPR 35 report:

- whether their prognosis is final or provisional
- whether further recovery, deterioration, or change is expected
- whether key milestones (e.g., scar maturation) have yet to be reached
- if a re-examination is necessary and when it should occur
- what matters remain unknown or unsettled.

Phrases such as "too early to say," "further review required," or "prognosis uncertain" will stop approval in its tracks. Ambiguity in expert evidence has direct procedural consequences and can cause uncertainty for the child and their family. It results in adjournments, further costs, and delayed compensation. Judges will simply not authorise an award where the evidence lacks clarity.

Conclusion

For experts, infant personal injury claims demand not only technical expertise, but also disciplined objectivity in the face of powerful emotional context. Particularly in those cases involving babies and toddlers, the absence of a direct narrative from the patient, reliance on evidence from others and the scrutiny of the infant approval process all heighten the importance of clarity, precision and independence as an expert.

Ultimately, the expert's role is not to advocate, reassure or resolve uncertainty prematurely, but to assist the court by providing robust, transparent, and clinically grounded opinion evidence. In doing so, experts play a critical role in ensuring that settlements are both fair and fully reflective of the infant's long-term interests.

It is also essential that experts consider the wider context of the use of their evidence. A well-prepared report, which is balanced, with a clear conclusion and prognosis is of great assistance to the court, reduces delay and ultimately supports the best outcome for the infant.

TRUTH, TRANSPARENCY, AND TECHNOLOGY: NAVIGATING AI AS A MEDICAL EXPERT WITNESS

By The Medico-Legal Knowledge Partnership (MLKP)

Introduction

The routine, everyday use of Generative Artificial Intelligence (AI) and Large Language Models (LLMs) is far from being a futuristic concept; it is fast becoming a reality. In fact, not a day goes by without the mention of AI. In the clinical negligence field, where medical expertise and opinion are applied to legal questions, AI has significant potential to improve efficiency, consistency, and speed[1]. It also runs the risk of causing mayhem and reputational harm[2], especially if deployed irresponsibly.

For the time being, adoption of AI among medical experts remains relatively low—around 20%, according to a recent Bond Solon survey[3]. However, a marked increase in its use is anticipated. For this reason, the MLKP Community has developed guidance for clinical negligence experts to raise awareness of the risks associated with using AI in their medico-legal work, and the steps they can take to ensure adherence to the Civil Procedure Rules (CPR) (1998)[4].

It is hoped that experts may be better equipped and able to navigate the evolving AI landscape, ensuring that any use of AI supports rather than undermines their independence, accuracy, and compliance with legal obligations.

The MLKP Community recognises that as AI becomes more deeply integrated into professional workflows, the Courts and instructing parties will increasingly question how experts use AI tools during report preparation. Clear principles and safeguards are therefore essential to maintain trust in expert evidence and confidence in the legal process.

What do medical experts need to know about generative AI?

At its core, the MLKP guidance flags a key limitation of AI systems for expert witness work —particularly large language models (LLMs)—insofar as they generate **predictions**, not **verified facts**. While such tools are capable of producing fluent, sophisticated output, they

are inherently prone to producing errors, including "hallucinations": plausible sounding but fabricated references, guidelines, or facts. This risk is structural, not accidental, meaning experts must never rely on AI outputs without robust verification.

This principle of the guidance aligns with CPR 35.3[5], which establishes the expert's overriding duty to the court[6] and clarified responsibility for GDPR compliance. The guidance sets out the legal and professional framework already in place. Even though no AI specific rule currently governs expert evidence, existing CPR provisions apply fully. The expert's duty of independence (PD 35 §2. 1)[7], the obligation to identify all materials relied upon (PD 35 §3.2)[8], and the statement of truth requirement (PD 35 §3.3) all demand transparency in how AI contributes to a report.

How risky are the risks?

An expert who incorporates unverified AI generated inaccuracies risks judicial criticism, defective evidence, and even negligence claims from clients.

Alongside technical and legal risks, the guidance identifies psychological and behavioural risks. Automation bias may lead experts to accept fluent but inaccurate AI wording; anchoring bias may cause initial AI suggested phrasing to shape subsequent reasoning; confirmation bias may subtly reinforce preexisting conclusions. To counter these risks, experts should actively interrogate AI suggestions, ensuring they do not inadvertently shift the strength or direction of their professional opinions.

To support safe practice, the draft guidance categorises AI use into three risk levels:

Lower risk tasks include proofreading, grammar correction, formatting, and generating glossaries—activities analogous to traditional writing and established IT software tools. These are acceptable provided the expert checks that meaning is not altered.

Medium risk activities involve summarising large documents or generating outlines, where hallucinations or omissions pose genuine risks. These outputs should be treated purely as internal aids and must not enter a report unchecked.

High risk uses, such as generating chronologies, literature reviews, or substantive analysis, carry the greatest danger. Any content used must be independently verified, rewritten in the expert's own words, and disclosed as material relied upon under PD 35.3.2 .

What about data privacy?

A major theme running through the guidance is the critical importance of data privacy. Experts must not enter personal or patient identifiable information into public AI tools such as ChatGPT, Gemini, or Claude. These platforms processing data externally, often use inputs for model training, and cannot guarantee GDPR compliance. if it is necessary for an expert to input patient data into an AI tool, then only secure, closed system, enterprise-level AI tools with appropriate data protection safeguards should be used - and, even then, anonymisation should be applied wherever possible.

How should medical experts disclose the appropriate use of AI?

The guidance document also outlines what experts must disclose when AI has been used substantively. If AI generated material is relied upon, experts must identify the tool used, the purpose, and the verification process undertaken. They must retain a record of prompts, outputs, and any changes made to their reports. While no dedicated AI disclaimer is required, transparency is mandatory under existing rules and where appropriate a disclaimer could be helpful to provide clarification.

What does a roadmap look like for future practice?

Before engaging any tool, experts should understand where their data is processed, whether it may be used for model training, whether a Data Processing Addendum (DPA) is in place, and whether GDPR conditions are satisfied. Public chatbots should always be treated as though the inputs could become public.

Further information

What is the Medico-Legal Knowledge Partnership (MLKP)?

The Medico-Legal Knowledge Partnership (MLKP)

formed its Community for experts, lawyers, and healthcare organisations in 2024. Its mission is to improve standards in medico-legal practice and to enhance legal outcomes and ultimately patient care, through collaboration and professional support.

With a growing active Community of over 360 members, it has run a series of webinars, expert surveys, and Q&A sessions focused on tackling some of the biggest challenges facing medical experts and legal practitioners working in the clinical negligence field today.

We invite medico-legal professionals to join our free MLKP Community and review the Guidance on the responsible use of Generative AI and LLMs for clinical negligence expert witnesses; visit our website to learn more (https://mlkpcommunity.com/).

Our partner organization, MLKP Services, provides customisable administrative support to medico-legal experts, providing a cybersecure cloud-based system to work within, supporting secure AI governance and ensuring GDPR compliance. To learn more and set up a free consultation please contact them via their website (https://mlkpservices.com/).

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MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry of the first quarter of 2026

NEWS

Lost Years Claims Rule Overturned

In the landmark case of *CCC v Sheffield Teaching Hospitals NHS Foundation Trust [2026] UKSC 5*, the Supreme Court ruled that young children are no longer barred from claiming "lost years" damages. This decision in the sad case of a hypoxic birth injury, handed down on 18 February 2026, overturned a 40-year-old precedent that had previously restricted these claims to adults and adolescents.

Key Legal Changes include:

Removal of the age bar, when The Court overruled *Croke v Wiseman [1982]*, which had prevented young children from recovering damages for earnings they would have made during years of life lost due to negligence.

Children now have the same rights as adults to claim for pecuniary losses (primarily lost earnings) occurring during the years they would have lived but for the injury.

The Court confirmed that a claimant does not need to prove they would have had financial dependants in the future to qualify for these damages.

While assessing a child's future career is difficult, this uncertainty does not justify denying compensation and Judges must assess damages as best they can based on available evidence.

Read more: https://supremecourt.uk/cases/press-summary/uksc-2023-0111

Civil Procedure (Amendment) Rules 2026 and 193rd Practice Direction Update

On 6th April 2026, the latest updates to CPR and PD came into effect.

Updates that may be of interest to medical expert witnesses include:

Statutory appeals and appeals subject to special provision – Amendments to update PD52D to clarify the process for appeals by professionals regulated under the Anaesthesia Associates and Physician Associates Order 2024.

Extending the Online Civil Money Claims (OCMC) Pilot PD51R and the Mediation Pilot PD51ZE – Amendments made to align the end date and to extend each pilot until April 2027.

Pre-Action Protocol (PAP) Update – The Road Traffic Small Claims PAP is updated to reflect a name change.

Read more: https://www.justice.gov.uk/courts/procedure-rules/civil

Yaser Jabbar GOSH Limb Surgeon Investigation

An independent review by the Royal College of Surgeons confirmed that former Great Ormond Street Hospital surgeon Yaser Jabbar caused harm to 94 children, with 35 suffering severe, permanent injuries between 2017 and 2022.

All 789 of his GOSH patients from this timeline were reviewed by independent Paediatric Orthopaedic Surgeons from other UK hospitals to assess the care these patients had received and determine if they had come to harm.

The investigation highlighted a dysfunctional department and "unsuitable" surgical practices, leading to a major patient recall and a police review.

GOSH Orthopaedics Department now has regular meetings with Royal National Orthopaedic Hospital to discuss complex cases with a wider specialist team and has strengthened processes to discuss care that has not gone to plan at monthly Mortality and Morbidity Meetings.

Wider learnings and actions are being applied across the hospital including a "Speak Up" culture supporting patients to raise concerns, and improving induction processes and training a cohort of mentors.

Read more: https://www.bbc.co.uk/news/articles/cq841e4n4v8o

Maternity and Neonatal Equalities Dashboard launched

NHS England has launched a new interactive dashboard for Maternity and Neonatal Services. This follows a Secretary of State announcement in 2025, with the aim of achieving equality in these services for vulnerable groups in the long term.

The dashboard brings together key information to address health inequalities in maternity and neonatal care services from a range of data sources, with breakdowns by ethnicity and deprivation.

Sources include: MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), Maternity Survey - Care Quality Commission, and the Maternity Services Data Set (MSDS), NHS England.

Read more: https://digital.nhs.uk/dashboards/maternity-and-neonatal-equalities-dashboard

Mazur Appeal Judgement

The Mazur case (*Chartered Institute of Legal Executives (CILEX) v Mazur and others*) is a landmark legal regulatory decision in England and Wales concerning who is permitted to conduct litigation under the Legal Services Act 2007 (LSA). The Court of Appeal overturned the High Court's 2025 strict interpretation and now the position remains as it always has - non-solicitors can conduct litigation if they are properly supervised by a solicitor.

Delegation is lawful in that unauthorised individuals (e.g. paralegals or support staff) can carry out tasks that form part of litigation, provided they are acting for and on behalf of an authorised person (such as a solicitor or authorised CILEX practitioner).

Responsibility remains with the authorised individual for the conduct of litigation, including professional duties (to the client and the court).

From the point of view of expert witnesses receiving instruction from law firms, they can be confident that dealing with support staff from a law firm is acceptable and should not impact their indemnity protection.

Read more: https://www.judiciary.uk/wp-content/uploads/2026/03/Mazur.APPROVEDJUDGMENTS.1.pdf

Royal College of Emergency Medicine (RCEM) Corridor Care Survey

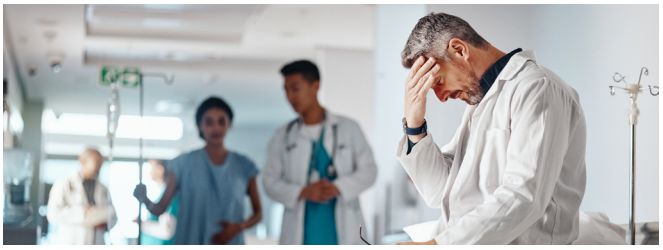
"If this was any other sector, there would be howling rage. If it was an airline, we would be grounding aircraft."

Dr Ian Higginson spoke recently at the Parliament Health and Social Care Committee about the unacceptable impact of corridor care and long waits on patients.

At the hearing in March, he answered questions from MPs on corridor care and the A&E crisis, and explained what must be done to improve the situation.

It coincided with the publication of a new RCEM survey of clinical leads in England, 88% of whom reported that they see overcrowding on a daily basis in their departments, 51% of respondents said their ED was fairly or very unsafe, compared with just 28% who said their ED was very or fairly safe.

Read more: https://rcem.ac.uk/press-release/morale-is-non-existent-clinicians-sound-alarm-over-patient-safety-concerns-in-englands-emergency-departments/



The Clinical Negligence Bill 2026

Brought by Catherine McKinnell MP, on 17 March 2026, The Clinical Negligence Bill, entered Parliament as a response to the ever-growing cost of clinical negligence litigation. This Private Members' Bill, brought under the Ten-Minute Rule, aims to reform the UK's clinical negligence system by reducing legal costs and improving safety, particularly in maternity care.

Key Objectives of the Bill

The Bill proposes several significant reforms to how medical negligence is handled and compensated in the UK:

Fixed Recoverable Costs (FRC): Extends fixed cost limits to clinical negligence claims valued under £25,000. McKinnell noted that currently, only £1 in every £5 spent on these lower-value claims reaches the patient, with the rest absorbed by legal fees.

Maternity and Obstetric Reform: Mandates the Secretary of State to report on options for reforming compensation specifically in obstetric cases.

Proposes updates to the Law Reform (Personal Injuries) Act 1948: McKinnell argues that the current law creates an "anomaly" where the state is "double-charged" because claimants can recover costs for private healthcare while still potentially using the NHS for ongoing treatment.

International Research: Calls for government research into "no-fault" international models, such as those in New Zealand, Japan, and Sweden, to foster a system built on learning rather than blame.

Read more: https://bills.parliament.uk/bills/4103#:~:text=A%20Bill%20to%20make%20provision,respect%20of%20certain%20cases%20of

The Senior Courts Costs Office (SCCO) Clarifies the Recoverability of Medical Reporting Organisation (MRO) Fees

Key Findings on MRO Fees in the landmark case of *JXX v Archibald [2026] EWHC 630 (SCCO).*

Classification as Disbursements: Senior Costs Judge Rowley ruled that MRO fees are properly characterised as disbursements, not "outsourced solicitor work". This classification removes the need for medical agencies to provide the exhaustive, time-based breakdowns typically required of solicitors.

The court established that a 25% markup on the underlying expert's fee is the maximum reasonable amount recoverable between parties (inter partes). Any markup claimed above this limit will be reduced to 25%, while markups below 25% will be allowed as claimed.

For simplicity, this 25% uplift cap applies to the entire expert invoice, including disbursements like expert travel costs, rather than just the report preparation itself.

The immediate practical impact includes:

Transparency: MROs are now encouraged to clearly state the percentage markup on their invoices to facilitate easier assessment by the courts; and

Recoverability Shortfall: Markups exceeding 25% (which previously ranged from 30% to over 100%) may still be payable as between solicitor and client but cannot be recovered from the losing defendant.

Read more: https://www.bailii.org/ew/cases/EWHC/Costs/2026/630.html

MEDICO LEGAL

MAGAZINE

EXPERT WITNESS DIRECTORY

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Experts in Medicolegal Reporting

PMS have provided more than 2,200 reports on Clinical Negligence in Obstetrics and Gynaecology over 30 years.

RICHARD PYPER

MB BChir FRCS(Ed) FRCOG

Consultant Gynaecologist

Winner of Lawyer Monthly Expert Witness Award 2025. After 32 years' experience as an Expert Witness on clinical negligence cases in Obstetrics and Gynaecology, Richard now concentrates on Gynaecological claims, specialising in **Urogynaecology**, including vaginal mesh and TVT cases.

Over 1,250 reports have been prepared for both claimants and defendants on Breach and Causation, as well as Condition and Prognosis. 90 Single Joint Expert reports were written, concerning a group urogynaecology litigation in Liverpool.

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RUTH MASON

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Consultant Obstetrician

Ruth Mason holds the Cardiff University Bond Solon Civil Expert Witness Certificate and has been providing expert reports since 2016 providing over 50 reports a year. She has a broad experience of all aspects of obstetrics and is involved in risk management. She provides expert reports for both claimant and defence and is happy to act as a Single Joint Expert. Ruth regularly acts as expert witness for HM Coroner in cases involving intrapartum and early neonatal deaths. She was awarded **AI Best Obstetrics Expert Witness 2024 (UK)**.

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RAHILA KHAN

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Consultant Obstetrician

Rahila Khan is the lead in **Maternal Medicine** at Worthing Hospital and joint lead of the Sussex **Maternal Medicine** network team of Worthing Hospital. She has extensive experience of **high-risk pregnancy and intrapartum management**.

She has written many Obstetric reports including cases of shoulder dystocia, uterine rupture, and massive post-partum haemorrhage. Expert opinion has often been provided on birth injury, HIE, cerebral palsy and stillbirth.

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JIM ENGLISH

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Consultant Gynaecologist and Pelvic Surgeon

Jim English has been a consultant gynaecologist since 1998 and has specialised in **laparoscopic pelvic surgery** and **endometriosis**, being the lead surgeon in one of the largest specialist endometriosis centres in Europe. He previously served as chief of women's and children's services at Worthing and Southlands NHS Trust and for three years on the council of the British Society for Gynaecological Endoscopy. He is currently an advisory board member of the European Endometriosis League and has published and presented extensively on endometriosis and laparoscopic pelvic surgery. For the past few years he has provided expert opinion on a range of cases relating to his specialty.

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Mr Paul Baguley is a triple-qualified Consultant in Paediatric Medicine, Emergency Medicine, and Plastic & Reconstructive Surgery, with additional expertise in Paediatric Plastic Surgery. Over a forty-year career, he has combined frontline emergency practice with complex reconstructive and aesthetic surgery. As a Senior Physician in both adult and paediatric emergency medicine, he brings unique cross-specialty insight to medico-legal work. Mr Baguley provides balanced, evidence-based expert reports on breach of duty, causation, and prognosis for claimant and defendant solicitors across the UK and Ireland.

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- Consultant Plastic Surgeon since 1996 and has a broad experience having worked in the Army, the NHS and the Private Sector.
- Over 20 years of experience writing reports and receives about 300 instructions per year.
- Instructed by Claimants, Defendants, and as a Joint Expert.
- Aware of the Part 35 requirements of an Expert Witness and has obtained Part 1 of the Certificate of Medical Reporting (Bond Solon).
- Has experience appearing in court as an expert witness.
- Appointments are available in Bristol, London, Cardiff, Birmingham and Salisbury.
- All reports are produced within agreed timescales, usually 6 weeks, which can be expedited.

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Produced medico-legal reports since 2000 for solicitors –by direct instruction or via third parties such as Premex, Injury QED and the GMC (fitness to practice investigation). This includes medical negligence work. 2024 produced 90 reports which included personal injury and criminal cases where erectile dysfunction given as a defence against an alleged sexual crime.

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Andrew Chukwuemeka

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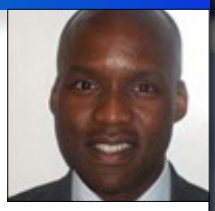

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Acting for Claimants, Defendants and as a single joint expert, a Consultant Cardiothoracic Surgeon with Imperial College Healthcare NHS Trust, he is Medical Director at Hammersmith Hospital and was previously Clinical Director for Cardiac Sciences (Cardiology, Cardiothoracic and Vascular Surgery). His clinical interests include Chest Trauma, Aortic Surgery including Transcatheter Aortic Valve Implantation (TAVI), Heart Valve and Coronary Artery Bypass Surgery.

Mr Chukwuemeka was the Royal College of Surgeons' Regional Specialty Advisor and served on the Medical Technologies Committee at NICE. He serves on the NHSE - Clinical Reference Group for Cardiac Services, NHSE - London Clinical Senate Council and the Medicines and Healthcare products Regulatory Agency (MHRA).

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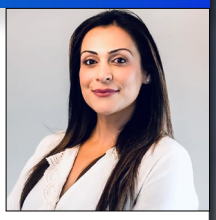
Robena Dhadda

Dhadda and Associates



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Dhadda & Associates is led by Ms Robena Dhadda, Consultant Speech and Language Therapist with over 20 years' post-qualification experience. She specialises in complex communication and swallowing disorders in adults and children arising from neurological disability, brain injury, and co-existing medical or mental health conditions. As Founder and Director of Speech Tools Therapy Ltd, she provides national clinical leadership and specialist rehabilitation services. Ms Dhadda has prepared over 400 CPR Part 35-compliant reports and has given expert evidence in Winterbotham v Shahrak (2024). She maintains active clinical practice, ensuring opinions are grounded in current expertise and upholds independence, impartiality, and evidence-based practice.

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EYE-LAW CHAMBERS® was founded in 2017 through the consolidation of leading medicolegal practices. Specialising exclusively in eye and vision-related medicolegal matters, the team offers high-quality CPR35-compliant expert opinion across issues involving causation, liability, condition, and prognosis. A corporate membership in The Academy of Experts since 2019, EYE-LAW CHAMBERS® acts as trusted expert medicolegal providers through its unwavering commitment to expertise, timeliness, and service. Based in London and operating internationally, for civil and criminal courts and tribunals across the UK, Republic of Ireland, mainland Europe, Africa, and Asia, EYE-LAW CHAMBERS® delivers comprehensive Expert reports within four weeks of instruction.

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Dr Suprio Ganguly has over 37 years' experience of radiology practice earned in five countries spanning three continents, traversing both military and civilian sectors. Dr Ganguly is on the GMC's Expert Witness and Associate Medical Performance Assessor panels. Dr Ganguly undertakes expert witness instructions, including the preparation of medico-legal reports and giving evidence in court in clinical negligence cases relating to Neuro, Chest, abdomen and pelvis, Gynaecology and obstetrics, Paediatric, Cancers, Trauma, and Emergency radiology. Dr Ganguly can act on behalf of either claimant or defendant or as a Single Joint Expert. He has provided expert witness evidence in the coroner's, judicial, and military courts.

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Tonia Goman is a Certified Expert Witness and specialist Skin Camouflage Practitioner with over twenty years' clinical experience in dermatology and scar management. She provides independent CPR-compliant medicolegal reports for claimant and defendant solicitors nationwide, including remote assessments, treatment planning and detailed quantum costings. Tonia advises on the suitability, application and long-term requirements of medical-grade skin camouflage for scars, burns and disfigurement. Originally trained with the British Association of Skin Camouflage, she works independently from her Bristol clinic and offers consultations and expert assessments across the UK, both remotely and face-to-face. Tonia provides balanced, practical and evidence-based expert opinion to the courts.

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Mr Joshi is an award winning, US and UK trained Consultant Thoracic Surgeon (in practice since 2018). He takes instructions on cases related to lung / thoracic cancers, pleural and airway diseases, sarcoma and many other lung / chest related conditions. He has a regular, ongoing trauma practice and can opine on both rib and sternal injury. Mr Joshi has been preparing reports since 2019 and has given evidence in Court. He is formally trained through Bond Solon and has CUBS certification. He takes instruction for both claimant and defense as well as a joint expert.

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A Fellow of the Royal College of Pathologists and the Royal College of Physicians, Dr Russell Keenan has been a Consultant Paediatric Haematologist since 2002. Dr Keenan worked solely in the NHS for 34 years from 1990 to 2024, including 22 years as a consultant, and now works part time for a private haematology laboratory. He was a director of the Haemophilia Centre for 15 years, taking the clinical and laboratory lead for all bleeding and blood clotting disorders and has published research articles across a range of haematological disorders including blood clotting. He has also written textbook chapters, including a chapter for a major international textbook, on all aspects of bleeding and blood clotting. Dr Keenan has 15 years' experience writing medico-legal expert reports for family, civil and criminal cases. He has given evidence in court in relation to these reports and has experience of cross examination.

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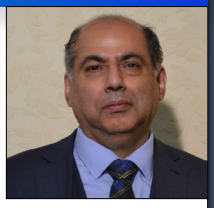

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Mr Khanna is a substantive NHS Consultant in Plastic, Reconstructive and Hand Surgery at The Sandwell and West Birmingham NHS Trust and has been involved in medical legal work since 1998. In this period he has provided over 4000 medical reports. He has prepared a chapter for the Encyclopedia of Forensic & Legal Medicine entitled "Medical malpractice in Cosmetic and Plastic Surgery".

Areas of expertise:

- Hand surgery: Sequelae of hand injuries and surgery
- Soft tissue injury:
- Burns management: Sequelae of disability following burns injury, scarring and surgery
- Medical negligence in Cosmetic Surgery

EMAIL ME

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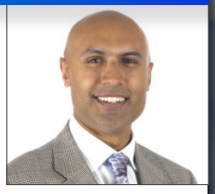

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Dr Raj Kumar has written over 600 reports in matters arising from patient and regulatory complaints, dental negligence and accidental injuries. Dr Kumar currently completes about 150 reports annually; 70:30 claimant defendant ratio. Clinical negligence, Condition and Prognosis, Road traffic accidents and Clinical Fraud are all covered. Dr Kumar has appeared in court hearings at least 5 times on behalf of claimants and defendants, including Regulatory matters. Dr Kumar qualified from Guys Hospital in 1989 with a BDS. In 1990 he obtained his LDS RCS from the Royal College of Surgeons London. Dr Kumar holds a Masters degree in Advanced General Dentistry from the Royal College of Surgeons and a Masters in Implantology from the University of Madrid.

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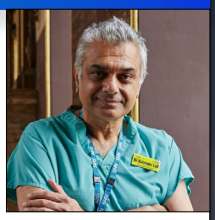
Mr Kumar is a Consultant Orthopaedic Surgeon, specialising in trauma and upper limb conditions, with a focus on medicolegal practice since 2011. He serves on the Orthopaedic trauma rota at the Royal Lancaster Infirmary. He holds an LLM in Medical Law & Ethics and is on the Medicolegal Committee of the British Orthopaedic Association. He is on the panel of performance assessors for the General Medical Council and is an examiner for the FRCS (Tr& Orth) and Royal College of Surgeons. He provides concise medical reports for clinical negligence and personal injury cases, with clinics in Manchester, Lytham, Bolton and Lancaster.

EMAIL ME

Kulvinder Lall

Consultant Cardiothoracic Surgeon



Consultant Orthopaedic and Trauma Surgeon

e: cardiothoraciclegal@icloud.com
w: www.cardiothoracic-surgeon.co.uk

Kulvinder Lall is one of the top cardiothoracic surgeon's in the UK, with particular expertise in aortic valve replacement, mitral valve repair, coronary artery bypass graft, and thoracic aortic aneurysm. Mr Lall is listed on the General Medical Council Specialist Register as a specialist in cardiothoracic surgery. Qualifying in 1989 from the University of London, he has trained in cardiothoracic surgery in London, Glasgow & Sydney. He was appointed to St Bartholomew's Hospital as one of the youngest cardiac surgeons in the UK aged 36. As an NHS Surgeon he has performed in excess of 5,000 heart operations with outstanding results as measured by The Care Quality Commission & Department of Health.

As a leading cardiothoracic surgeon, he has published in over 15 peer reviewed worldwide journals and is actively involved in NHS research. He teaches extensively in China, Europe, Hong Kong and Israel, and was the first implanter of a stentless heart valve in Asia (Beijing 2010).

VISIT WEBSITE

Mr. Damian Lake

MB,Ch.B,FRCOphth,LLM.

All General Ophthalmology

w: www.damianlake.com
e: info@damianlake.com

Mr. Lake is a Consultant Ophthalmologist currently practising in Kent, Sussex and London. In 2008 Mr. Lake became a Consultant at the Queen Victoria NHS hospital, East Grinstead. He became Clinical Director of the service for five years, and responsible for the UK's first Eye Bank. Mr. Lake has represented the hospital at National level at OTAG (Ocular Tissue Advisory Group to NHSBT) and as Chair of the OTTSG (Ocular Tissue and transplant Standards Group of the Royal College of Ophthalmology.) In 2022, Mr. Lake obtained a Masters degree (with merit) in Law from The University of Cardiff. In 2023, Mr. Lake founded The Sight Centre Group and opened clinics and hospitals in Tunbridge Wells, Kent, dedicated to excellence in eye care. He continues as the Medical Director and a practising Consultant. Mr. Lake has produced medico legal reports since 2008, with an approximate 50:50 split, Defendant: Claimant ratio.

EMAIL ME

Mr Jonathan Luck

MB ChB FRCS FRCOphth MEWI

Consultant Ophthalmologist

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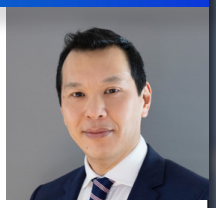
A practicing NHS Consultant Ophthalmologist, Mr Luck has over 25 years' experience in providing medicolegal opinion and reports. He will accept instructions as an Expert Witness in most aspects of general ophthalmology, but has a special interest in Cataract Surgery, Trauma, Laser Eye Surgery and Paediatric Ophthalmology (including alleged non-accidental injury). He aims to provide timely, reasoned, logical, and thorough medical reports, which can be fully CPR Part 35 Compliant, or short 'screening' reports, according to his instructions. Mr Luck regularly undertakes CPD in medicolegal matters and was awarded the Cardiff University Bond Solon Expert Witness Certificate in 2019.

VISIT WEBSITE

Dr Neil Mo

BSc (Hons), MSc, MBBCh, FRCP



Consultant Rheumatologist

t: +44 0800 433 2380
e: enquiries@drneilmo.com
w: www.drneilmo.com

Dr Neil Mo is a consultant rheumatologist and clinical lead in Swansea Bay University Health Board. He was previously a consultant in Charing Cross and Hammersmith Hospitals. He has received training in report writing and courtroom skills, and has produced over 300 medicolegal reports. He provides comprehensive, authoritative and well balanced reports with a quick turnaround time. He has expertise in all areas of adult rheumatology, and maintains his clinical and medicolegal knowledge to deliver an up to date expert opinion. He is experienced with risk management within the NHS and has undergone training with NHS resolution.

EMAIL ME

Dr Ana Phelps

MD, PhD, FRCP, RCPathME

Substantive Consultant Geriatrician

t: +44 07970 627 996
e: ana.phelps@nhs.net

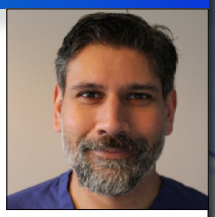
Dr Phelps is a substantive Consultant Geriatrician at Buckinghamshire Healthcare NHS Trust. She is an experienced Medical Examiner, regularly reviewing hospital mortality cases and advising doctors on medical certification of cause of death and when to refer to a Coroner. Her expertise includes Orthogeriatrics, Frailty, Dementia, Peri-operative Medicine and complex cases in patients >65y. Her medico-legal practice includes medical negligence, second opinions, decisions on escalation and resuscitation, coroner reports, ethical situations, inappropriate/ harmful testing and treatments, and breeches in communication. She can provide comprehensive case reviews and expert opinion on the quality of the care provided at the different stages of care.

EMAIL ME

Dr David Newby

BSc MBChB FRCA LLM

ANAESTHESIA EXPERT WITNESS



Consultant Paediatric and Adult Anaesthetist

t: +44 07428 467 803
e: ddp.medicolegal@gmail.com
w: www.anaesthesiamedicalexpert.co.uk

Dr David Newby is a substantive anaesthetic consultant at Ipswich Hospital. He is the lead anaesthestist for paediatric services and established and runs the consultant-led paediatric preoperative assessment clinic. His adult work includes orthopaedic trauma and vascular surgery.

Areas of particular expertise:

- anaesthesia for children in the district general hospital
- paediatric preoperative assessment
- TIVA in children

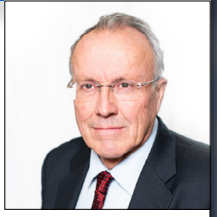
In addition to:

- all aspects of adult perioperative care, including preoperative assessment
- high-risk surgery
- awareness under anaesthesia
- anaphylaxis
- shared-decision making

EMAIL ME

P N Plowman

MA MD FRCP FRCR



Senior Clinical Oncologist

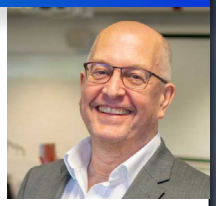
t: +44 020 7631 1632
e: nplowman@doctorplowman.com
w: www.drnickplowman.com

Dr P N Plowman is senior clinical oncologist to St Bartholomew's Hospital, London and has a paediatric interest and on the staff of Great Ormond Street Hospital. He has a long history of medicolegal work with around 50 new instructions each year. He has been an expert in the Tobacco Litigation and the class action of 22,000 USA women claiming breast cancer caused by HRT. Most of his instructions are to do with delay to diagnosis of cancer or causation aspects of cancer treatments' complications.

EMAIL ME

Dr Stuart Porter

Lecturer in Physiotherapy | Expert Witness | Author



t: +44 7530 479177
e: stuartbporter@aol.com

Dr Stuart Porter is a Chartered Physiotherapist and an Expert Witness with extensive experience. He is also an international textbook author. His medico-legal practice encompasses breach of duty, causation, and condition-and-prognosis matters within physiotherapy, rehabilitation, and wider neuro musculoskeletal healthcare in adults and children. He accepts instructions on behalf of both Claimants and Defendants, including legal aid rates, providing independent expert opinion in accordance with the Civil Procedure Rules (CPR Part 35) and associated Practice Directions. His reports address standards of physiotherapy practice, assault, negligence and criminal claims, the appropriateness of interventions in relation to accepted professional and evidential standards. Dr Porter routinely analyses the adequacy of physical assessment, documentation, treatment protocols, patient consent, and continuity of care.

EMAIL ME

Mr Aruni Sen

MS, FRCS, FRCEM, DipMedEd.

Lead Consultant in Emergency Medicine, Princess Elizabeth Hospital, Guernsey

t: +44 07839 755 001
e: thesens@msn.com

Medico Legal Expert since 1996
Experience as independent expert for claimant, defence & SJE.

Areas of interest:

- Clinical Negligence
- Personal Injury
- Hand Injury
- Resuscitation
- Trauma, Burns, Sedation & Acute Pain
- Musculoskeletal injuries
- CPR Part35 trained
- MEDCO accredited
- Up to date medico-legal CPD portfolio
- Reports vetted by solicitors
- Consultation Venues at: Chester (Cheshire, Northwest & North Wales), Guernsey & Jersey
- Happy to provide pro-bono opinion

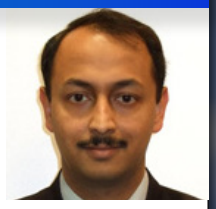
Member of EWI, APIL, Law Society.

EMAIL ME

Mr Nikhil Shah

FRCS(Tr & Orth) FRCS MCh(Orth) MS(Orth) DNB(Orth) MBBS

Consultant Trauma & Orthopaedic Surgeon



t: +44 0161 393 3059
e: nikhil.shah@consultantcare.com

Mr Nikhil Shah can act as an expert witness in personal injury and clinical negligence cases, taking instructions from either claimant or defendant or as a Single Joint Expert. He can provide medico legal reports for personal injury claims involving:

- Trips and slips
- Pelvic and acetabular fractures
- Low velocity impact cases
- Whiplash
- Long bone and articular fractures
- Ankle, knee and hip fractures, lower limb injuries
- Soft tissue injuries

Mr Shah can provide clinical negligence related reports in his specialist areas of expertise concerning:

- Primary and revision hip and knee replacements
- Pelvic and acetabular fractures
- Long bone and periarticular trauma

EMAIL ME

Robyn Webber

Consultant Urological Surgeon

t: +44 7915 423 924
e: medicalreport@btinternet.com

Mrs Webber has been a consultant urological surgeon for over 25 years, working in both the NHS and the private sector. She is based at the Victoria Hospital in Kirkcaldy, part of NHS Fife University Health Board. She has been in medicolegal practice since 2007 and currently writes 75 reports per year. She undertakes cases from all parts of the United Kingdom and the Irish Republic.

Areas of expertise:

- Injuries to the genitourinary tract, including renal and pelvic trauma
- Clinical negligence, including
  - Delayed diagnosis of urological conditions
  - Complications following the implantation of TVT/TOT mesh devices
  - Urinary sepsis
  - Management of stone disease
  - Informed consent

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