The Inns of Court College of Advocacy

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EXCELLENCE IN ADVOCACY

Training Films

Expert Witnesses

Introduction and Narration: Joanna Korner CMG QC

Judge: His Honourable Mr Justice Pegden

Counsel for Claimant: David Etherington QC

Counsel for Defendant: Anthony Leonard QC

Consultant Neurologist (Ms. Penne): Dr Colette Griffin

Professor Hermitage: Sarah Clarke

(transcript of video)

A

Joanna Korner CMG QC: The aim of this film which you're about to see, is to provide you with an introduction to the principal and techniques of dealing with expert evidence.

B

The film is divided into three sections:

- First of all the conference of the expert
- Second; the calling in chief of the expert - this case is one of clinical negligence, but it will be treated as if it were a criminal trial, for the purposes of showing you how an expert is called in-chief
- And third; there will be cross examination of the expert

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In each of the sections they have all been truncated. In real life a conference, examination and cross-examination might well take hours in a case of this kind. Equally the speed at which the examination-in-chief and cross-examination are conducted are somewhat greater than you will probably find in a real trial.

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Before we come to these areas of dealing with expert evidence, you may need to decide whether you actually need or want to call an expert at all. If you come to the conclusion that you do, then some of the criteria you need to take into account are as follows:

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- How senior is your expert?
- Is your expert one that is genuinely an expert in the field about which you require evidence? And just as importantly - is he or she recognised as such?
- Have they given evidence before? If so, was it on behalf on the claimant, or the defendant? Or on both sides?
- And finally - and most importantly - will your expert be persuasive?

H

A The case you're about to see is one of clinical negligence, the claimant in this case - a lady named Holly Rudd - had a brain operation. That operation was conducted by Mr. Ingham; a neurosurgeon - and he is the defendant in the case.

B As a result of the operation, Mrs. Rudd had increased disability to both her leg and her arm. You're going to hear more details about the case in conference which follows, that conference will be conducted by David Etherington QC.

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Screen Text: *Conference*

D **David Etherington QC:** Understanding, examining, using and cross-examining expert witnesses can be challenging, even for the most experienced advocates. Unlike general witnesses, experts are entitled not just to give evidence based on their considerable expertise, but also to express opinions upon it. You have to

E decide what - if any - expert evidence you need, and how best to present it. And what - if any - expert evidence produced by the opposing party you need to challenge, and how best to do it.

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The central question is how you comprehend what the essential issues of expert evidence are, and how you present your evidence and theories to the court most

G coherently, and challenge the opposing expert evidence most effectively. The key is preparation: avoid the slap-dash approach such as:

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H **David Etherington QC**: Mmm? Yep, a con with Ms. Penne? Who's Ms. Penne? Oh no, the Cumberland Lodge case... well stall her for ten minutes while I read through the papers!

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David Etherington QC: One thing you need to establish from your expert is how the specific expertise has been obtained. Try to avoid presenting to the court a list of qualifications showing your expert must be very clever. Explore with your witness at conference what they've done in their professional career both educationally and professionally which allows them to speak with authority on the real issues in the case. For instance, the following is not going to assist you much:

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David Etherington QC: Hello Ms. Penne would you run through your qualifications for me?

Ms. Penne: I've been a consultant neurosurgeon for the last 35 years, I'm a world expert in the field of Arteriovenous Malformation, I've published over 450 peer-reviewed papers in the last ten years

David Etherington QC: OK that's great, and I gather you have a special interest in this AVM problem?

Ms. Penne: Oh yes definitely

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David Etherington QC: You'd be surprised how many times the presentation of an expert's qualifications in court comes out like a garbled list, or are taken as read. Contrast it with this approach:

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David Etherington QC: Ms. Penne you know this case is about whether the claimant should have been operated on at all, and if so whether she was given the appropriate warnings. Would you help the court with this - what is it about

your education and practical experience which gives you a special interest and authority on these topics?

Ms. Penne: As one of the leading world experts in these field, I have had 35 years of experience of going through the case with the patient, and actually going through the pros and cons of the surgery and the risks. It's a very difficult part of medicine to explain to lay people, therefore I'm one of the experts in my field of actually having ways of going through this with the patient so they understand the risks and the pros and the cons of the procedure.

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David Etherington QC: The qualifications, which were just a jumble of degrees and so on beforehand, are related and linked now to the matter in hand. When you meet the expert remember that it is you who is the expert in the legal aspects of the case - including procedure. However remember it is *not* you who is the expert on the area with which you are asking the expert to assist. You don't have to prove to the expert that you know a lot about it, by trying to do so you may miss something fundamental which the expert fails to tell you because it's wrongly assumed you already know it. So, avoid this:

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Ms. Penne: My examinations of the X-rays and the scans, indicates to me that part of the Nidus of the AVM lies over the Motor Strip

David Etherington QC: (*internal thoughts, narrated*): The Nidus...the Nidus...what's the Nidus? What's the AVM?

David Etherington QC: Okay! So Ms. Penne, you're quite satisfied that part of the Nidus of the AVM did not lie over the crucial Motor Strip?

Ms. Penne: Absolutely, that's what I say in my report

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David Etherington QC: On the contrary, never, never be frightened to look a fool. In expert terms, and by comparison, we're all fools when dealing with enormously complex topics, to which these experts have devoted their lives. So ask about everything and anything you don't completely understand.

So…

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David Etherington QC: Forgive me Ms Penne, but between these four walls would you tell me exactly what the Nidus and the AVM are, assuming I know nothing about medicine in general and the brain in particular?

Ms. Penne: The AVM stands for Arteriovenous Malformation; it's an abnormality of vessels within the brain, consisting of areas where arteries and the veins actually lie in very close contact with each other. Normally there are very small arteries called capillaries that go between the veins and the arteries, and normally they stop the flow of blood being too great through the veins. However with the AVM there is a great build-up of pressure within a very small area of the brain which is why you run into problems with haemorrhage and all the other problems that we get.

David Etherington QC: In fact better still would you draw them for me?

Ms. Penne: Well here's a rather helpful diagram from my most recently published paper…

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David Etherington QC: Another common error is to use the conference to reassure yourself that your report is solid, without testing it robustly enough against other expert evidence.

So…

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David Etherington QC: So what you're saying is this: you're looking at those video images and are quite satisfied that the Nidus did not lie over the Motor Strip?

Ms. Penne: Exactly

David Etherington QC: Excellent

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David Etherington QC: A better line of questioning might be:

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David Etherington QC: I need to understand exactly what you say when you say the Nidus did not lie over the Motor Strip when Professor Hermitage says it did. Can you put the case against us on this and how we answer it?

Ms. Penne: Well, one of the big problems will be that when two different clinicians look at the same set of X-rays they can often come to completely different opinions about it. I'm quite confident that Conrad Whay used the correct method, which is the Rewington-Waddington method, however it is difficult to argue the exact position, because as experts we will indeed, differ in our opinions regarding that.

David Etherington QC: And in fact I think I see that it was you that saved my mistake - that the Nidus did lie over the Motor Strip?

Ms. Penne: It is, yes

David Etherington QC: Thank you

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David Etherington QC: To do this as effectively as you can you need to understand the opposition you are facing, and understand terms used in the opposing report just as thoroughly as you do your own. So if the expert uses any other technical language at any other stage that you don't completely understand again ask for an explanation as if to a child.

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David Etherington QC: You mentioned a calliper, just tell me simply and clearly what a calliper is...

Ms. Penne: A calliper is a piece of metal that lies over someone's foot to actually keep the foot in the correct position. If you think back to the age-old pictures of children with polio they will often have had a calliper on their foot

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David Etherington QC: Of course, you need to know something about any weaknesses in the opposition expert if there are any. What you don't want is the expert's version of office politics, about how her expertise is better than his.

So this needs careful avoiding…

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David Etherington QC: Any tips on how to deal with Professor Hermitage? Is he as good as you?

Ms. Penne: Well there was that rather unfortunate episode of the PhD student and the way in which the... erm, research had actually been written up and published in the journal about ten years ago…

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David Etherington QC: Much better is to ask:

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David Etherington QC: Would you tell me any objective weaknesses in Professor Hermitage's methodology, and any objective limitations on his area of expertise as compared with yours?

Ms. Penne: Well he does have one rather worrying conclusion that he comes to in the last page of his report, where he very clearly says that he thinks the motor weakness of the arm and the leg was due to either an infection or a haematoma that was post-operative. Quite where he gets that information from I'm very unclear, and he also backs that up by saying that it was clearly missed by the intensive care unit staff... again there's absolutely no logical way that I can formulate the same opinion and I don't know where he got that from

David Etherington QC: Yes

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David Etherington QC: Finally in the conference you have a valuable opportunity to see what sort of witness your expert will make. Is she or he too short in the answers? Does she go on forever? Is she or he unusually aggressive or defensive?

A If so note these things to remind you months later how you should deal with this expert in the witness box.

B If the expert has advanced particular theories in conference, test as far as you can to see if these will be held to under cross-examination - or you'll be left stranded in court.

C Conferences may involve oral additions by the expert to the existing report. You should ask the expert to write an addendum to the existing report - if this has happened - and you'll need to consider whether this requires disclosure. If you are relying on the report, any additional report must be disclosed. If you're

D prosecuting in a criminal case, you should also consider your duty to disclose anything said by the expert in conference which may assist the defence.

E At court you are generally entitled to have any expert witness instructed on behalf of your client present, in either a civil or a criminal case, during the evidence of the other relevant expert witness.

F This can be very useful, beware one pitfall however: your expert can help you whilst you're cross-examining the opposing expert, this can however become distracting if the expert is constantly telling you things or bombarding you with notes which you may not fully understand.

G Try to avoid this sort of scenario:

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H **David Etherington QC:** You formed the same conclusion as Dr. Liam Beth did you? Having looked at all the films?

Professor Hermitage: Yes

Ms. Penne (*to David Etherington QC*): Ask her if she used any magnification techniques

David Etherington QC: Did you use any magnification techniques?

Professor Hermitage: Sorry I've no idea what you are talking about

David Etherington QC (*to Ms. Penne*): What **are** we talking about?

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David Etherington QC: This chain can go on for even more embarrassing exchanges, with the barrister not controlling the flow and becoming little more than glove puppet in-between the two experts.

If you expert has issues ask the judge for some time to consider them at the end of cross-examination, but before you sit down.

Never feel rushed into putting a question which you have not considered, as the asking of questions in court is your area of expertise. If the judge refuses you time you're still almost always better off considering the problem afterwards and finding another method of dealing with the point. Just asking questions you don't understand is reckless gambling with a poor prognosis.

So, hard work, a structured and prepared approach, the intelligent use of diagrams and pictures, and above all complete humility when approaching expert evidence are keys to maximising the advantages of having an expert and avoiding some of the pitfalls.

Do this and you will be able to concentrate more calmly and more effectively on the area of expertise entrusted to you, namely the most effective presentation of the relevant expert issues in court, and a greater likelihood that you will persuade

A the tribunal of fact that the weight of opinion is more on your side than the other.

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Screen Text: *The Trial*

Joanna Korner CMG QC: Having had at least a day's conference with his expert, C David Etherington is now ready to proceed with examination-in-chief.

The case has been listed before Mr Justice Pegden, as you will see examination in chief of an expert will always begin with the expert's qualifications and expertise, D followed by an explanation of the expert's opinion and how they reached that opinion. And finally the conclusion that the expert has reached together with reasons for that conclusion.

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Screen Text: *Examination-In-Chief*

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Anthony Leonard QC: Your honour my learned friend Mr Etherington is about to call his witness; Penne. I have as my expert Professor Hermitage who has been delayed and cannot be here for another hour and half. I respectfully require my G witness to be here in order to listen to the opposing expert's evidence.

Mr Justice Pegden: Well where is he Mr. Leonard?

Anthony Leonard QC: She, your Honour - she is at another court as your Honour H knows she gives evidence on a number of occasions. She was supposed to have finished her evidence yesterday but she's overrun

Mr Justice Pegden: No Mr. Leonard I'm afraid I'm not prepared to delay this evidence until then, of course I'll give you time to have a consultation with her when she gets here but meanwhile this evidence must continue

Anthony Leonard QC: I understand

Mr Justice Pegden: Mr Etherington may I turn to you - are there agreed documents that the court can have in respect to this evidence?

David Etherington QC: Your honour there's an agreed lexicon of medical terms and definitions, and medical literature that is agreed

Mr Justice Pegden: I'm very grateful to you

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David Etherington QC: …And you are Ms. Denise Penne? And you are a consultant neurosurgeon is that right?

Ms. Penne: I am yes.

David Etherington QC: Well Ms Penne you know that the issues in this case are: first of all, should the claimant have been operated upon at all?

Ms. Penne: That is correct yes.

David Etherington QC: That is the principal issue as you understand it

Ms. Penne: Yes

David Etherington QC: And if so was she given the appropriate warnings?

Ms. Penne: Yes

David Etherington QC: Now we can see from the literature that there are an impressive list of qualifications that you appear to have, I want to ask you what it is about your education that and practical experience as a neurosurgeon which assists you answer these questions?

Ms. Penne: I've been a practising consultant neurosurgeon for the last 35 years-

David Etherington QC: -What does a neurosurgeon actually do?

Ms. Penne: In laymen's terms it's a brain surgeon.

David Etherington QC: Thank you, you were saying?

Ms. Penne: In 35 years I have performed hundreds of similar operations to the operation we're talking about and I have world expertise in both the operation itself and research into the causes of the Arteriovenous Malformation

I there have years of experience of guiding patients through this extremely difficult and traumatic decision that we as professionals are asking them to undertake

David Etherington QC: Now you talked about Arterio Vascular Abnormalities, and we I think see this as the initial "AVM" in the literature. Again just in simple terms what is an AVM?

Ms. Penne: An AVM - as you rightly point out - is short for Arteriovenous Malformation. Normally the arteries and the veins are very separate and they are connected by small capillaries, and-

David Etherington QC: -And what's a capillary?

Ms. Penne: A capillary is like an artery, but it's much smaller calibre.

David Etherington QC: Yes

Ms. Penne: And essentially this controls the amount of blood flowing through the venous system, which means that the blood coming through the arteries is at very high pressure.

So therefore when then the AVM forms there's an abnormal connection between the artery and the vein, which means that there's a huge build-up of pressure in this abnormal collection of vessels.

David Etherington QC: If that condition is existing in a patient, is it something that arises at birth or can arise at any time during life?

Ms. Penne: It's felt that the susceptibility is there from birth, however there's no way of predicting at what stage in one's life... lifetime this will actually develop.

David Etherington QC: If one could access the brain and simply look at what you're describing, what would be the best physical description that might help us understand what it simply looks like to the eye?

Ms. Penne: It's really like a bag of worms.

David Etherington QC: Now in this particular case, have you had an opportunity to examine the X-rays and the scans?

Ms. Penne: I have yes.

David Etherington QC: And as far as the X-rays and then scans are concerned, what is your own interpretation of the significance of them?

Ms. Penne: What's significant is it's very clear to me that the Nidus - which is the main part of AVM - is lying over the Motor Strip of the brain.

David Etherington QC: And again, what is the Motor Strip of the brain? What is its significance?

Ms. Penne: The Motor Strip of the bran is the part of the brain that is responsible for the motor of the arms and the legs, so essentially the movement of the arm or the leg.

David Etherington QC: Now we know that there is a report in this case from a Doctor Conrad Whey, who's a consultant neuro-radiologist. Now first of all what's a neuro-radiologist?

Ms. Penne: A neuro-radiologist is a consultant who specialises in looking and examining at the images that are taken or either by an X-ray or an angiogram, so rather than looking at the patient they look at the scans.

David Etherington QC: And before you were consulted about this case did you know Dr. Conrad Whay and his work?

Ms. Penne: We've been working together for over 30 years, yes.

David Etherington QC: Reading and considering his view, does that in any way effect the view that you formed, either to make it stronger or weaker?

Ms. Penne: He agrees entirely with my view.

David Etherington QC: Now how does he establish the precise location of the Nidus, this mass of the abnormality that looks like worms?

Ms. Penne: He uses what we call the Rewington-Waddington method, which is a worldwide accepted technical method of using a geometric grid to actually measure the size and the position of the AVM.

David Etherington QC: And how exactly is that done? Is it through a scan? Through radiology?

Ms. Penne: It's done by looking at the scan.

David Etherington QC: Right, thank you.

Now, on looking at the Nidus of this particular abnormality was there anything about it that was unusual?

Ms. Penne: There was in the fact that there was an indistinct halo around the central portion of the AVM, and this tells me that at a microscopic level there were elements of the AVM growing out in an indistinct fashion from a central portion of the AVM into the surrounding normal tissue.

David Etherington QC: Again the halo that you've talked about what would that look like to somebody examining the scan?

Ms. Penne: Again it's very much like an indistinct halo margin around the AVM.

David Etherington QC: Now as far as halos are concerned presumably you've encountered those before in your career?

Ms. Penne: I have, yes.

David Etherington QC: And on the scale of distinctness of halo, where does this one fit?

Ms. Penne: It's fairly indistinct but it is still present.

David Etherington QC: What is the significance - if any - of there being such a halo?

Ms. Penne: The significance is that for the operating surgeon it will make the operation much more difficult, and technically tricky.

David Etherington QC: Now if the halo is **more** distinct, does this increase the difficulty of this operation? Or is it just simply the presence of any halo that matters?

Ms. Penne: It's the presence of any halo that matters.

David Etherington QC: Ms. Penne I've asked you about the halo that you saw surrounding the Nidus, may I just ask you now a question about the lesion itself - the AVM itself? Is there a way of categorising the degree of seriousness of a lesion?

Ms. Penne: Yes, is a classic paper by Speltzer et al from 1992 that grades the size, the position and the diffuseness of the AVM into classes from one to six-

David Etherington QC: -And may I just ask you: are the classes for each of those things you mentioned, or is the class for the lesion as a whole taking into account all those features?

Ms. Penne: The latter, so taking into account all those features.

David Etherington QC: And in your opinion, what class was the lesion in this case?

Ms. Penne: It was a class five.

David Etherington QC: And, can you tell us in terms of less serious to more serious, how do the numbers go in the class - what classes are there?

Ms. Penne: One is the least serious and six is the most serious.

David Etherington QC: When one is operating in this area around the Motor Strip, what are the principal risks?

Ms. Penne: The most important risk is the risk to the adjacent part of the Motor Strip. The way that the Motor Strip is organised is that the portion affecting the leg is extremely close to that affecting the arm. So by definition if the AVM is

A overlying the Motor Strip affecting the leg it's only a matter of millimetres before you reach the portion affecting the arm.

B **David Etherington QC**: Right, well now since you've mentioned the arm may I ask you if you were able to assess the degree of risk to the arm on the left side in this particular case?

C **Ms. Penne**: I think there would have been a very high risk due to the close nature of the two parts of the Motor Strip.

D **David Etherington QC**: Now there's two matters you mentioned so far, one is the halo-effect, and the other is the location of the Nidus. Would you be able to say which one of those two contributes the more to the risk, or are they equal? Or is one non-contributory?

E **Ms. Penne**: They're both very important, the position of the AVM is somewhat more important than the halo but the two together are extremely important.

F **David Etherington QC**: Now before the operation, in your opinion were there any clinical signs that the AVM was affecting the Motor Strip - clinical signs in the patient?

G **Ms. Penne**: Yes because we have Holly Rudd describing the fact that her shoe kept falling off her left foot… so that tells me that her foot was weak.

H **David Etherington QC:** And from the record and notes that you've considered, in your opinion was there any sign that the operating surgeon had appreciated this before the operation?

Ms. Penne: There was because he states that he also noted that the shoe was falling off her foot.

David Etherington QC: Are you able to say in your opinion, whether the results of the operation - in other words what happened afterwards - reflects the risks that you have yourself told us was existing?

Ms. Penne: It does, yes.

David Etherington QC: As far as you are concerned in your opinion, and I want you to consider this question very carefully, can you find any other reason for the symptoms and damage that this claimant suffered after the operation other than the features you've already told us about?

Ms. Penne: I can't, no.

David Etherington QC: Would you wait there please there'll be some more questions.

Mr Justice Pegden: Yes Mr. Leonard?

Anthony Leonard QC: My expert is very close to the court now, might I just have 20 minutes please?

Mr Justice Pegden: Yes if she is close by Mr. Leonard certainly I'll allow you that short period of time.

Anthony Leonard QC: Thank you very much.

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Joanna Korner CMG QC: You will have noticed that David Etherington was still using in his examination-in-chief of his expert the techniques which are common to all examinations in chief.

For example:

- He highlighted the areas to which he was moving in his questioning for the benefit of the judge, the jury and indeed his own witness
- He used what is commonly called the piggy-backing technique; in other words he framed his next question from the answer that he'd been given by the witness
- And although he asked leading questions, this was only when there was no dispute about the matters about which he was asking questions… And contrast that to his questioning when it came to the disputed areas.

So we now move to cross-examination of the expert, to be conducted by Anthony Leonard QC. The first thing to remember is that you will always have the benefit of your own expert sitting behind you during the course of your examination. Some of the principles to be followed are these:

- Don't, whatever you do, argue with the witness
- Begin if at all possible by establishing with the witness what is agreed between the two sides, without of course allowing the expert simply to repeat his examination-in-chief
- Make sure during the course of your cross-examination that the judge and the jury understand the points that you are making
- And finally: only ask leading questions if at all possible, if you begin to ask open-ended questions it gives the expert a chance simply to repeat what they've already said in-chief

Screen Text: *Cross-examination*

Anthony Leonard QC: Ms. Penne you've had an opportunity to look at the qualifications and experience of Mr. Ingham have you not?

Ms. Penne: I have yes.

Anthony Leonard QC: Might I just refer you to page 27 of the papers? You accept that he's a highly experienced neurosurgeon?

Ms. Penne: I do, yes.

Anthony Leonard QC: He has both a good academic background and long experience as a consultant neurosurgeon?

Ms. Penne: He does yes.

Anthony Leonard QC: Indeed in terms of experience I think a year or two more than you, but there's very little in it?

Ms. Penne: That is correct yes.

Anthony Leonard QC: And you accept - as Counsel's already put to you - that his handling of the operation cannot be criticised?

Ms. Penne: That is correct yes.

Anthony Leonard QC: Even despite that substantial length of the operation you do not - to quote your words - I'm looking your Honour at page 23 - "criticise the surgeon or the manner in which he performed the surgery"?

Ms. Penne: That is correct.

Anthony Leonard QC: Could you now turn to page 17 please? Which is the agreed schedule of medical literature.

Ms. Penne: Yes

Anthony Leonard QC: You no doubt were consulted by the claimant's solicitors in order to put together an agreed document of medical literature?

Ms. Penne: That is correct yes.

Anthony Leonard QC: And what has been put together there is the authoritative, or the most authoritative medical literature on this particular subject with which the court has to grapple?

Ms. Penne: That is correct.

Anthony Leonard QC: And could you turn to the next page - page 18 - and do you see halfway down there are the beginning of two quotations from literature provided by Professor Hermitage?

Ms. Penne: That is correct.

Anthony Leonard QC: It follows that he is recognised - I'm so sorry - *she* is recognised as an expert in this area?

Ms. Penne: Relatively so, but the cohort was extremely small.

Anthony Leonard QC: Mmm, but in quoting in two places including from the *Journal of Neurosurgery and Psychiatry* you're accepting are you not that she has expertise in this particular subject?

Ms. Penne: I am yes.

Anthony Leonard QC: Now you accept that at the time that Mrs Rudd presented herself for the CT scan, and then the angiogram in February of 1999 she was suffering from a Speltzer class five AVM?

Ms. Penne: That is correct, yes.

Anthony Leonard QC: Well now with that in mind let's look at the position prior to the operation itself:

A Speltzer class five is associated in a patient not only firstly with a significant risk of death, but also a significant risk of illness or immobility?

Ms. Penne: It is yes.

Anthony Leonard QC: It's what you describe as morbidity?

Ms. Penne: That is correct, yes.

Anthony Leonard QC: Untreated, a class five lesion can therefore lead to seizures?

Ms. Penne: It can do.

Anthony Leonard QC: Explain what you mean by seizures?

Ms. Penne: A seizure is an epileptic fit, whereby the patient becomes unconscious.

Anthony Leonard QC: And it won't just happen once if it's untreated it could happen again, and again, and again?

Ms. Penne: It could potentially happen, yes.

Anthony Leonard QC: Secondly, you could have a bleed within the brain?

Ms. Penne: You could do, yes.

Anthony Leonard QC: And that will have fatal consequences?

Ms. Penne: Not necessarily so, sometimes it can but sometimes it doesn't.

Anthony Leonard QC: So there's a risk that the bleed within the brain will lead to a fatal result?

Ms. Penne: There is a risk yes.

Anthony Leonard QC: And thirdly, the patient will suffer from neurological signs, i.e. a worsening of the patient's disabilities?

Ms. Penne: They can sometimes do although she had very little in the way disability with just some weakness of part of her foot.

Anthony Leonard QC: But bearing in mind that she has a class five Speltzer, there's a likelihood is there not left untreated that it will worsen?

Ms. Penne: There is a likelihood yes.

Anthony Leonard QC: Risks and percentages are always difficult, but can we put it this way that it would be reasonable to assume that the risk of death is approximately one percent?

Ms. Penne: That is correct yes.

Anthony Leonard QC: Putting that in stark terms of every 100 patients that you see one is going to die?

Ms. Penne: And 99 aren't.

Anthony Leonard QC: And in medical terms a one percent risk would be termed as a considerable risk of death?

Ms. Penne: It would be a considerable risk of death yes.

Anthony Leonard QC: The symptoms displayed by Mrs Rudd were never going to get better were they?

Ms. Penne: No

Anthony Leonard QC: They could only get worse?

Ms. Penne: Perhaps over time yes.

Anthony Leonard QC: Now as to the speed with which an AVM will grow inside her head, there is no realistic way of giving it a timetable is there?

Ms. Penne: No there isn't.

Anthony Leonard QC: It may continue for months, even for years?

Ms. Penne: It may do yes.

Anthony Leonard QC: Before there's any significant deterioration?

Ms. Penne: That is correct.

Anthony Leonard QC: On the other hand, with a class five Spetzer it's more likely that there will be significant deterioration?

Ms. Penne: There is, although it has to be said that she hadn't deteriorated thus far.

Anthony Leonard QC: Looking at it this way, if it was class two let's say or a class three, you would be looking at a different circumstance entirely, from a class five, or indeed a class six?

Ms. Penne: You would be yes.

Anthony Leonard QC: Now a patient such as this, presenting with a class five, you have two options do you not, as a neurosurgeon?

You can watch the patient and monitor the progress of the AVM - and see if it increases in size?

Ms. Penne: You can do yes.

Anthony Leonard QC: As it compresses the adjacent tissue of the brain?

Ms. Penne: That is correct, yes.

Anthony Leonard QC: Or, you can operate?

Ms. Penne: You can do yes.

Anthony Leonard QC: And relieve that pressure?

Ms. Penne: And potentially cause much more devastating disability to the patient, yes.

Anthony Leonard QC: Well let's just look at the first of those two courses, if you decide to watch and wait. However gradually it happens it will continue to grow will it not?

Ms. Penne: It will do yes.

Anthony Leonard QC: And if it progresses from a class five to a class six Speltzer it will become of a size that would render it inoperable?

Ms. Penne: That is correct yes.

Anthony Leonard QC: You simply would not operate on a class six?

Ms. Penne: You would not, no.

Anthony Leonard QC: And there's a risk is there not, that even a day after you have classified through looking at the... looking at the... forgive me I've forgotten for a moment...

Ms. Penne: It's a scan.

Anthony Leonard QC: Thank you - the scan, the CT scan, thank you - and the angiogram, that even the day after that there is a risk that she could have a massive bleed?

Ms. Penne: There is but it may not happen for 30 or 40 years, we have no way of telling that.

Anthony Leonard QC: No way of telling whether it will be for 30 or 40 years or the next day?

Ms. Penne: Absolutely

Anthony Leonard QC: And if she has a massive bleed the next day she dies?

Ms. Penne: She may do.

Anthony Leonard QC: Forgive me, if she has a massive bleed of the brain she will die?

Ms. Penne: No, not necessarily; there are plenty of patients who have massive bleeds who we can manage to save their lives so it's not necessarily going to happen.

Anthony Leonard QC: Whilst a surgeon will advise on the risks of operating or not operating, at the end of the day it's a decision for the patient alone is it not?

Ms. Penne: With our guidance, yes.

Anthony Leonard QC: Absolutely, you're there to guide but it must be the patient who makes the final decision?

Ms. Penne: It must be yes.

Anthony Leonard QC: I want to just deal now with a different topic which is the size of the AVM, again you've agreed that a class five is operable, a class six is not?

Ms. Penne: I have yes.

Anthony Leonard QC: The physical difference in size between a class five and a class six, are we talking about millimetres or less?

Ms. Penne: We're talking about millimetres.

Anthony Leonard QC: The neuro-radiologist and the neurosurgeon will work closely together will they not in determining the size of the AVM?

Ms. Penne: That is correct yes.

Anthony Leonard QC: Each using their expertise?

Ms. Penne: Correct

Anthony Leonard QC: And using their combined expertise, they will be able to judge as best they're able the extent of and the position of the AVM?

Ms. Penne: Correct, yes.

Anthony Leonard QC: And you accept in this case that there were highly trained individuals performing both of those tasks?

Ms. Penne: I do accept that yes.

Anthony Leonard QC: It is not an exact science is it?

Ms. Penne: It is not, no.

Anthony Leonard QC: And it's not until you've opened up the head and you can look with your own eyes that you can judge to perfection the size and the position of the AVM?

Ms. Penne: That is also correct yes.

Anthony Leonard QC: So at that stage again you have two choices don't you? You can sew the head back up without interfering, or you can operate?

Ms. Penne: That is correct yes.

Anthony Leonard QC: Let's again examine the effect of those two options, firstly, to close the head back up - there would be no prospect of another operation thereafter would there?

Ms. Penne: No there wouldn't be.

Anthony Leonard QC: And because when you get to the class six size it'll be inoperable that's really an end of the surgical route?

Ms. Penne: It is yes.

Anthony Leonard QC: And the result is that you consign the patient to a deteriorating state of health, however long it may take?

Ms. Penne: Theoretically so yes.

Anthony Leonard QC: And, what you have described as a considerable risk of death?

Ms. Penne: That is correct yes.

Anthony Leonard QC: Or you can operate?

Ms. Penne: Yes

Anthony Leonard QC: A class five is operable?

Ms. Penne: Yes it is.

Anthony Leonard QC: And if you remove the whole of the clot the chances are of a full recovery?

Ms. Penne: That is correct yes.

Anthony Leonard QC: If you only remove part of it, you run a risk that it will grow again?

Ms. Penne: You do yes.

Anthony Leonard QC: You do not of course criticise in any way the skill displayed by Mr. Ingham in this long operation?

Ms. Penne: I do not, no.

Anthony Leonard QC: So does it come down to this please - where the AVM was precisely, and to what extend it had encroached on the Nidus could only be found when the surgeon opened up the head and looked at it for him or herself?

Ms. Penne: No it's more accurate to look at it in the scans before the operation because one part of the cortex actually looks very similar to another part so it's often quite difficult to know.

Anthony Leonard QC: Well forgive me Ms. Penne that's quite contrary to what you've said about three minutes to go when you accepted what I put to you then that it's only when the surgeon is looking for himself that you can - to a nicety - see the position and the extend of the AVM, do you want to-

Ms. Penne: -Sorry I thought you meant just the size of the AVM rather than its exact position on the Motor Strip.

Anthony Leonard QC: And it follows that's something you yourself never had an opportunity to do?

Ms. Penne: No in this case no.

Anthony Leonard QC: No, you have to rely on the CT scan and the angiogram?

Ms. Penne: That is correct yes.

Anthony Leonard QC: So in these circumstances you only get one shot at whether you operate or not?

Ms. Penne: That is correct yes.

Anthony Leonard QC: It was a now or never decision?

Ms. Penne: It was yes.

Anthony Leonard QC: Whether you agree or not with the decision that was taken in this case do you accept that Mr. Ingham, from what you have already told us, was best-placed to make that decision?

Ms. Penne: He was yes.

Anthony Leonard QC: And does it really amount to this - faced with that position, some experts would operate, some would not?

Ms. Penne: That is correct yes.

Anthony Leonard QC: Your Honour may I just have a moment to consult?

Mr Justice Pegden: Yes

Anthony Leonard QC: No I have no further questions thank you.

Mr Justice Pegden: Thank you Mr. Leonard

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Joanna Korner CMG QC: You've just seen Anthony Leonard cross-examine the expert, and what did you notice in that cross-examination?

- First of all, he got the expert to explain what she meant by "seizures", when he didn't get the answer he repeated the question

- And the reason for that is later, it's quite often the question that the tryer of fact will remember, and indeed Anthony in turn will call his expert to give the answer that he was expected from the one he was cross-examining
- You saw also how important it is to listen to the evidence, because there comes sometimes a contradiction of the earlier evidence - as you saw in this case
- Also notice how Anthony built his cross-examination to get to the point where the expert was forced to agree with that Mr. Ingham was in the best position to judge what the right course was for this lady; Holly Rudd
- And finally, although firm throughout his cross-examination Anthony was - as always - unfailingly polite

We hope this short film has been of some practical help to you. The training which you will receive which follows this film will obviously go into these areas in rather more depth.

Finally, this film is a tribute to the memory of Richard Davies QC; bencher of the Inner Temple, and committed advocacy trainer. He would have taken part in this film, had it not been for his sudden death.

END

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