Ethical preparation of winning written statements and affidavits - Cameron Jackson-1st February 2023

Introduction

I've been thinking for some time about the fact that the primary evidence in pretty much all jurisdictions that I appear is now written evidence, and this is a change that's occurred over the last quarter century or so which has fundamentally changed the way in which a hearing is conducted.

In some respects, it has fundamentally changed our perception of our doctor's evidence in chief.

However, it seemed to me that pretty much all of the principles of advocacy apply equally with respect to witness statements as they do to oral evidence in chief, because witness statements are now the evidence in chief.

So all the advocacy skills that you would apply to leading evidence in chief really apply in one way or another to witness statements, but so often we just see them as paperwork. I wanted to have a little bit of an exploration of that. The reason I think a well prepared witness statement is critical is that the witness statement is the first time a tribunal member or a coroner or a court hears the story from the doctor's perspective, just as oral evidence in chief once was.

The witness statement should tell the story in the doctor's own words, in the way that we want it to be told, and in the order that we want it to be told, and giving priority to what we want to prioritise, so that the first impression the decision-maker will have of the matter is in a form over which we have control.

The decision-makers will read it even before they walk on to the bench, so it's really a priceless

opportunity to frame the narrative and tell the story the way that we want to tell the story. So why don't we just try and apply systematically the kind of approach we would apply to developing our oral advocacy to the issue of of witness statements?

Three stages to the preparation of witness statements

I've identified three phases to this process.

The first is just reviewing the brief and developing a case theory, giving some consideration to what it is you want to be able to say at the end of the case and what facts you would really need to have established in order to be able to do that, what evidence you would need in that statement, and what issues you would want to be focusing on.

That'll be the first issue that I'll explore.

The second issue that we'll be looking at is, all right, so you've read through the material, you're developing your case theory and the way you're looking at the case, how do you conference the doctor in a way that complies with your ethical obligations, and which maximises the chances that the evidence you get is accurate, truly reflects the doctor's recollection, and won't all fall apart under cross-examination?

Then the third, and probably this is the most important aspect, how do you then construct your witness statement in a way that maximises its impact and best supports the narrative of the case that you want to put forward, so you want to be at least three quarters of the way there after you've filed your witness statement so that you are still ahead after cross-examination.

First stage; what is it that we want in the witness statement?

(i) Develop and be guided by your case theory

So let's turn now to the first stage. How do we apply the principles of oral advocacy to determine what we're looking to put in the witness statement? In other words, how do we develop our case theory?

As I go through this process, what I will emerge is that at its best, it is not a purely defensive process; it is not just a question of responding to the case or issues as framed by the HCCC or the Coroner's Court.

This process starts with something you do all the time, reading through the evidence available to you, and the particulars of the complaint,

In coronial matters, the equivalent of the particulars of the complaint is the issues list.

You also go to the critical documents and as you're doing this, it's helpful to be thinking *"alright, what's the case theory available in this in this matter?"*, and this applies equally to coronial matters, as it does to disciplinary matters.

While you're doing all of this, it's helpful to prepare a chronology, which lists the facts as they come out of the statements and the material you're looking at.

It can be also helpful to categorise each fact as favourable, neutral, or damaging. As you're doing this, you need to try and develop a case theory that neutralises the damaging facts and accentuates the favourable facts.

So you're asking yourself the whole time, as you're going through the material, what is the narrative which best suits the doctor?

Does the weight of evidence support it?

What evidence is inconsistent with that narrative and what problems need to be addressed?

From this working case theory you work out what it is you want to be able to say in final submissions and therefore what evidence you need to seek in order to be able to say it. It's that working case theory that guides what evidence evidence you need from your doctor.

For instance, let's take a disciplinary matter. Of course, it's going to be driven by the particulars of the complaint, so if, for instance, the gist of the complaint is that the doctor performed an operation in a manner that departed so far from the standard expected of them that it amounted to professional misconduct.

Then the case theory that you developed may be that though there was a such a departure, there were particular reasons for it that would not cause the Tribunal to have broader concerns about the health and safety of the public, or it may be that it was not performed in such a manner. It may be that it was consistent with accepted standard standards and practice.

So you might have a number of possible approaches and you'll be exploring which one you want to take when you speak to your doctor, and you'll be exploring which one you want to take when you speak to the expert, but in the end your focus will tend in one direction or another.

What I want you to think about when you're going through this process is whether there's a positive case that you want to put, that you don't want to respond simply to the particulars and say, no, that's not right, this isn't right, and so on, and so on.

It's likely that what you'll be doing will not be simply a rebuttal of the particulars pleaded by the HCCC. The reason for that is that if you simply follow the outline given to you by the HCCC, then you're playing the HCCC's game and you're not thinking about it from the doctor's point of view. You're not considering whether the counter narrative is in fact almost independent of or not directly tethered to the way that the HCCC wants to plead the case. This is equally true in an inquest.

Imagine a case where the issues lists and any relevant observations in the expert evidence just raise a question about whether a psychiatrist assessment of a patient who went on to kill themselves was appropriate. Imagine you were the psychiatrist, who assessed the patient, and determined that they should be released from care and the patient then killed themselves?

One aspect of your case theory will likely be that you followed accepted protocols and that your care and treatment was adequate, and that you just can't predict when someone might commit suicide.

However, that's a pretty negative and defensive approach. It's got to be part of the approach, but your theory, your case theory might be that your psychiatrist is a compassionate, professional and caring practitioner, and that he provided exemplary care.

Example one; going beyond a purely defensive approach

An inquest that I appeared in several years ago in Newcastle demonstrated that point very well. It involved the death of a young man from an overdose of medication prescribed for him by the team of which our doctor was the the leader and he was the one who made the decision to discharge the patient. So he discharged the patient and within about half an hour, the patient had thrown themselves on railway tracks just outside of Newcastle, and was killed by a train.

Following a conference with the psychiatrist, we put on a supplementary witness statement. In the statement, the psychiatrist wrote powerfully and movingly of the predicament that the young man was in, about the choices which his healthcare team faced, and the decisions were which were made and the reasons they were made.

In his evidence in court, he spoke directly to the family about the predicament for the young man, describing the nature of a personality disorder in the most caring and helpful way for the family. He said;

"What it meant was that your son was not able to form the relationships and get the help that he needed", and that was an immensely helpful thing for the family who asked me to thank him personally for having given them that explanation, but it was also helpful in terms of the coroner's reasons, because the coroner directly referenced that explanation in Her Honour's reasons, and praised the psychiatrist and his team for the professional and considerate way in which they dealt with their patient.

What it left everybody feeling was that the last person who had seen this young man while he was alive had been compassionate and caring in the treatment that they had offered him.

So that's a way of thinking to yourself, if you have the right doctor, *"Do I have something more to offer than 'it's not my fault and I did everything I was supposed to'"?*, and I've found that it's not uncommon in the case of people who commit suicide that often there have been very caring and capable people looking after them.

I guess that's a general challenge to you when you're developing a case theory or thinking about what it is that you or your counsel want to be able to submit at the end of the hearing. Just think, is there a positive tale that we have to tell here? Or are we simply just saying, "*no, that's not right? No, we don't agree with this. No, we don't agree with that."*?

(ii) Conferences with doctors

Now the next topic I wanted to move on to is conferences with the doctor, and eliciting the evidence you want in their statement more generally.

I'm aware of the reality that, in disciplinary matters, what we often do is we send the particulars of the complaint to the doctor and we say, look, could you respond to this? That's a necessary part of the process. I guess I'm aware of the fact that often that will also be sufficient, and one way or another we'll cobble together a statement from this tooing and frooing.

And that's all fine, often, as long as you take some care with it, but what I want to suggest to you is there may be cases where you're able to spend some time either in conferences or in carefully constructed email questions doing something more than just putting the HCCC's case or the issues list or the expert report to the doctor and asking them for their reflections or their comments.

Approaching obtaining the contents of witness statements ethically and effectively

And there are some rules to follow if you go to this next stage and you are conferencing with the doctor either with or without counsel, or alternatively, you want to take a creative and imaginative approach to the written questions that you're asking.

A good way to think about it is that if you're asking written questions of the doctor in order to prepare their statement, they're like interrogatories in civil proceedings, except that we would call these *"interrogatories in chief"*, because they are to our own witnesses, not our opponent's.

So in other words, interrogatories are normally really just written cross examination; you're looking for to cross examine someone in writing and get their written response, but in this case, they are our evidence in chief, because we are obtaining evidence from our own witness.

Whether we are going to obtain that evidence in conference or we're going to be asking questions in the form of interrogatories, because they are our own witness all of the normal rules for evidence in chief apply.

And in fact there are two distinct rules in the advocacy rules about conferencing with witnesses, and the purpose of those rules is to make sure that we don't corrupt the witness's evidence and don't suggest to them what their evidence should be in a way that means that the answers they're giving are not really their actual recollection or their actual belief.

If you do start suggesting answers to a witness, or you do start influencing the evidence, there are two consequences. One, you're breaching the advocacy rules, so it's an ethical breach, but two, you won't get the best evidence out of them, and you'll leave them vulnerable to cross examination, because in cross-examination, they will revert to whatever they actually think or it will be revealed that they read someone else's statement about the same event and it influenced their thinking or something like that.

It might be a good idea to review those rules, because, it's probably been a while since you've looked at them. They're rules 24 and 25 of the uniform law, solicitors' conduct rules. The gist of them is is easy to understand; in essence, they are all directed towards ensuring the witness's evidence is not distorted by the way that the conference is conducted, and they serve the same purpose as the rules with respect to leading evidence in chief in court or in a tribunal.

One of the consequences of moving to witness statements is that it's very easy for us just to create statements that haven't come from the doctor, or they've come from old letters they wrote, or they've come from this and they've come from that. And it's brilliant because you can get ten pages in about twenty minutes, but it's not really what they would say if you put them on the in the witness box and

asked them questions.

A practical application of the ethical rules

Let's look at how the rules apply in a practical sense when you conduct a conference, or correspond with a doctor in preparing a statement.

First, you should ask non-leading questions.

This is often misunderstood. It doesn't mean you have to ask vague or general questions. It doesn't even mean that it's never alright to ask questions that could be answered yes or no. It just has to be clear that you're not suggesting that the answer has to be yes, or has to be no, or the question misdirects the witness.

Second, you're entitled to test the evidence, and you're entitled to challenge what the doctor says. You're entitled to say, *"Well, that doesn't sound plausible for these reasons"*, or you're entitled to say, *"Well, that doesn't seem consistent with what you said five minutes ago"*.

You are entitled to, and should, seek clarification of explanations or accounts which don't make sense, including medical explanations and accounts.

If what the doctor is saying to you is not making sense to you, the most likely explanation is that it doesn't make sense, and even if it does make sense, it could be clearer, and may well not make sense to a tribunal or a court.

You may find yourself saying to yourself *"oh look, maybe I just don't understand the medicine"*, but maybe the doctor doesn't understand the medicine. It's actually quite likely; and if they can't explain it to you, they don't understand it. We've all all got the vocabulary and the critical thinking skills. We couldn't

treat a patient, but we can understand what we're being told. So keep digging, digging, digging until you get an account that makes sense to you.

If someone's describing an operation, then get them to the level where you can see the operation happening as they describe it to them, because one of the one of the critical things, about any tribunal or court is that in effect, it's trying to see something that's already happened, happened in the past. It's not there anymore. There are traces of it in the medical records and traces of it in what people remember and what people say, but they can't actually see it, so you have a huge advantage if you can get a level of detail out of the doctor that brings what happened to life.

Example two; have the doctor describe something in a way that you can picture

That means you can accept something happened if you can imagine it. A disciplinary case in which I acted for a doctor last year provides a good illustration of this. At issue was the way in which an operation was performed.

The doctor in question had simply said in his early statements that he had "oversewn" an artery in the vessel in the neck as part of his effort to stem bleeding which had occurred as a result of his nicking the artery. An expert interpreted this as *"stapling"* the artery to the adjacent tissue, a procedure he was highly critical of.

We filed a further statement in which he described the procedure as follows;

"I passed the suture both over and under the bleeding vessel, making sure I engaged some of the surrounding tissue, and then I pulled it tight."

Then you can imagine that being done, and it almost doesn't matter unless there's something that just directly contradicts that having happened.

It will be accepted because people can see it happening. The Tribunal did accept it, and the relevant particular of the complaint was rejected.

We don’t really want to get too existential about it but what actually happened in the past is not something we can truly know. We're just trying to work it out now if our witness statements have that level of granular detail so that we can actually see it happening, in which case it feels real, and will usually be believed.

We don't always get there but it's something to aim for on critical facts in dispute, that we get an account that feels complete and that we can see in our own heads.

I'll get back to that when we're talking about the content, but for current purposes, it’s an absolutely critical point to keep in mind as you try to get sufficient detail from a doctor.

Just while we're still on the subject of what you're entitled to do, of course you're entitled to go through medical records with doctors, particularly their own records, but just following normal principles of leading oral evidence, which is to first ask the witness what they remember themselves with reference to the medical records. Only when they have told you what they remember themselves would you go to the record and then point out anything that's in there and ask the doctor *“look, does this change your recollection?”*.

You may want to address an inconsistency in their evidence when compared to someone else's notes, which is generally something you would only do if they were present when the note was made. If you want to do that, be careful about how you do it. Test whether they agree with what is recorded in the record, because they may not agree with it. They may, they probably will, and if they don’t, you are certainly entitled to say to them, *“look, usually medical records are given quite a lot of weight”*, but if they're adamant that something that's written in there didn't occur and if it's important to their case, you have to grapple with that, and if it is important, put it in their statement.

The rule against coaching; what you can and can’t do

Now there was one thing I just wanted to mention while we're on the topic of conferencing witnesses, and that is, there's a much misunderstood rule, a basic rule, which is the rule against coaching. You can’t tell a witness precisely what to say, but that doesn't mean you can't discuss with them the manner

in which they give their evidence. You are entitled to discuss with them the way in which they listen to questions and respond to questions, and so on and so forth.

Now there's sometimes, a bit of a grey area here, which I try to stay on the right side of, and that is, I point out to doctors that for a tribunal, or whatever the disciplinary body is really considering is *"would I be comfortable sending my partner, my child, my parent, to this doctor?"*

That's really in my opinion in disciplinary proceedings and to a certain extent in coronial and probably even in civil litigation to a certain extent the underlying question that's really going through the minds of the tribunal members, particularly the medical people on the tribunal, or the coroner, or the judge;

"Is this person safe? Would I be comfortable with allowing that doctor to treat patients?"

Now of course we know they are thinking, *"OK, I've got to deal with the factual issues"*, but what's going on at a less obvious way is that they are looking at the person before them and thinking, *"Are they behaving like a doctor? Are they answering questions like a doctor? Are they thinking like a doctor? Do they have the manner of a doctor?"*

Now all of these things are on the borderline of coaching if you point them out too much, but you can explain to the doctor that they that their presentation is something that's being considered by a tribunal or at an inquest and while they might get cross with questions, or this might happen or that might happen, if they can remain calm and approach questions rationally and with warmth, then that will leave a more favourable impression. Now these those sort of intangible things and I are absolutely critical.

We all know that certain doctors in disciplinary proceedings are going to have their registration cancelled because when we listen to them, we're just thinking *"Oh dear, you don't present as a capable doctor"*, and it's not even to do with the actual content of the answers, but it's to do with the manner of delivery and the lack of organisation in the responses.

The final rule of ethical witness preparation is that you should not conference witnesses together. The West Australian Bar Association has the most thorough practice guideline which takes it to the next level and says you can't show witnesses other people's affidavits, or other people's statements.

That's baloney, and the West Australian Court of Appeal has said that three times and rather than correct that, the Western Australian Bar Association just leaves it in there, even referring to cases which they think, erroneously, support them.

To work out what the principle really is, just go back to first principles.

Are you showing them the statement in a way that's likely to influence their evidence or corrupt their evidence? Or are you asking them for their to comment on an inconsistency? Or are you just checking whether it changes their recollection? So in other words, you can show them other statements, and in fact often they have the brief, but your aim is to do it in a way that doesn't cause them to change their evidence, simply because you want their evidence to be consistent with the other person's statement or for some other reason like that.

Second stage; what do you put in the witness statement and how do you organise it?

Now I want to get to the question of the actual witness statement itself. I shouldn't call it an exercise in creative writing, because that gives the wrong impression, but in some ways you are constructing a narrative just as you do with oral evidence.

A basic examination in chief involves saying *"oh, So what happened next? OK, can we get to the next complaint? So what happened next? And then what happened?"* Now obviously, that's not how you do an examination in chief, even though sometimes it'll work.

No. What you're really thinking is *"what are the precise questions I want to ask to allow the doctor to tell the story in the way that's most favourable to us, and highlights what we want to highlight"*.

(i) The reason why the reply to the complaint and the doctor's statement must be separate

When I was first briefed and disciplinary matters, the practise was that the reply to the particulars of the complaint and the witness statement were all one document, signed by the doctor.

No! Wrong! Don't do it.

There are a number of reasons not to do it that way. The first is just that it needs to be emphasised to the tribunal that the response to particulars is something that the lawyer takes responsibility for. It's a formal response to the complaint, and it's a way of indicating what is in issue in the proceedings. What does the respondent accept, what needs to be proved, and what is denied? Three separate things, not two.

What you're saying when you admit something is yes, that's not an issue. You might still want to say things about it in your witness statement, but the basic correctness of the particular, you say, is not in issue.

When you say it's not admitted, you're saying *"I'm putting you to proof on that"*. You're saying *"you, the HCCC need to prove it, and you, the Tribunal, you need to determine it."* It might be true. You don't know.

It might be something you don't know, or it might be something that you just say "*You just don't have the evidence for this"*. We're not denying it, we're just saying; *"you need to establish it"; It's sufficiently in doubt that you need to establish it"*.

Denying it is where you're saying "no, that's wrong", and then you need a proper basis for that denial, you need evidence to support your position.

Your evidence could be *"Look, it's just just no way that what you've got establishes that*" as opposed to *"you need to establish it."* So these are subtle differences between not admitting and denying, but you need to remember and observe the distinction.

The pleading is a formal document and the tribunal should look at it as that, and the form that they have prescribed at NCAT is helpful in that respect because it specificies the doctor's representative as the person to sign it. You should use that form, and you should sign it rather than the doctor, because we want to persuade the tribunal that that document is just a pleading. It's not evidence, it's a pleading.

Sometimes, even since I've kind of enforced this separation, I'll see the in the reply to the particulars of the complaint, *"but I did this"*, or "*but I did that"*; words that appear to come from the doctor, and look like evidence.

No, don't put it there. It doesn't go there. Put it in the doctor's witness statement. Now, the the other reason for observing a strict separation between response and statement, apart from helping everybody to understand that, yes, the response is just indicating what's in issue, it's not evidence, is that it can be used to show a lack of insight on the part of the doctor.

There may be decisions that are appropriately made by you as a lawyer about what should not be conceded (and thus not admitted) that represent forensic, legal decisions, rather than things that should be owned by the doctor, and if the doctor's just signing this one, big document and it all looks like evidence, then it looks like the doctor is saying "no, I don't admit that" and refusing to take responsibility for his conduct.

For example, I'm extremely reluctant to admit the ultimate issue in the case, which is that the doctor is guilty of professional misconduct as a formal matter.

I don't think it should be sheeted home to the doctor as an issue of insight that the pleadings are saying to the HCCC *"well, look, you prove that it is professional misconduct, you prove that you're entitled to cancel the doctor's registration"*.

There will be cases where you will conclude that we have to admit professional misconduct on the facts, but on the whole, perhaps with unsatisfactory professional conduct, yes, but the ultimate issue in the proceedings, professional misconduct, well, I think usually not.

The second thing is that if you look at the particulars as part of the doctor's evidence or response, then what ends up happening is the HCCC maintain total control of the narrative, and then it looks like the witness statement that follows is just kind of window dressing or extras or bits that just didn't fit as a response to the particulars rather than something structured the way you want to structure it, so the opportunity to control the narrative is lost if you do it that way.

You might decide, for instance, that in your doctor's witness statement, the story comes out better if your evidence addresses the second complaint or the third complaint first.

The complaints might not be in chronological order. They aren't always. You might decide the story works better in chronological order, or it might be that the second one is clearly less egregious than the first and shows evidence of having learned from the first. Or it may be that it works better in the opposite order.

These are things to to think about from the point of view of the decision-maker who's reading it because this is going to be how they first understand your doctor's actual evidence. They're simple examples. There are plenty of others.

You might simply respond to it in a way that doesn't directly follow the order or form of the particulars at all, and then you might just put a reference to the particular it is most relevant to.

The way that the story is told might not work best the way the HCCC has constructed the particulars, which is often according to their own agenda or according to some principle of utter chaos, where they've just thrown things in what seems to be a totally random fashion.

So you don't want the structure of your witness statement to be dictated by the whims or interests of the HCCC.

(ii) Structuring for maximum effect

When you're thinking about the structure, think about it as you would an article or a short story. A factual short story, of course, but think about where you want to place things? What do you want to put at the start? What's going to have maximum impact?

Where do you want to hide things on what page? The first thing a decision-maker is going to do before your doctor is called is read their witness statement, and it is from that witness statement that they will form their first impression of your doctor.

The HCCC's barrister is going to read it too. The way in which the witness statement is organised and the story told is going to affect the way that your doctor cross examined, so just think to yourself *"these are the ingredients, how do I want to organise them and how do I foreground what I want to foreground?",* in terms of the content.

(iii) Show, don't tell

We get back to what I was talking about before when we were talking about obtaining the evidence, show, don't tell, a fundamental principle of story-telling. Include what the witness perceived directly. Make it vivid. Make it particular. Address the *elements* that go into a particular conclusion, not the conclusion.

So if I get back to that example that I gave before, which comes from a real case, there was immense confusion from the use of a word over something that the particular doctor said that they did after they nicked an artery during an operation. They said that they over sewed the artery, and then they checked and there wasn't any more bleeding.

This caused a lot of confusion because one way of interpreting "oversewing" in this situation was just that kind of like stapling, you just put the thread into the tissue on one side of the artery, put it over the artery and attach it to the tissue on the other side, just like you would a staple over a piece of string, and that would not have been satisfactory.

What became clear, was that what oversewing meant in the way he was using it was what I described before, which we can picture.

We don't need to be doctors to understand that if you tie all the way round the artery and you just also capture some of the tissue lying behind the artery while you're doing it so that it's sort of secured

to the tissue but also wrapped all the way around the artery itself as well and then pulled tight, it is more secure, and we can picture the procedure being performed.

Because he was able to describe that in that way, and it wasn't inconsistent with the findings at the autopsy, that was just accepted as what had happened.

Now if you imagine that sort of thinking, if you can apply it, preferably at the earliest possible stage, and it's in the statement as clearly as that, then it will tend to be accepted and that's one particular of the complaint out of the way.

More broadly, what would you often see is something along the lines of *"I took great care during the operation to do this or to that"*.

Well, *"yeah"*, the Tribunal would think, *"I'm sure you would say that."*

However, what we really need to ask is, well, what do you mean? What did you actually do that demonstrates care?

We don't necessarily need a picture of all of the operation, but if we have a picture of all the critical parts, if we have a picture of that which demonstrates care, then we can accept that care was taken, because we can imagine and we can see in our head it's happening and particularly the relevant specialist on the Tribunal will see it.

Now we had a specialist sitting on the Tribunal in the case to which I referred to whom the word "oversew" meant a different thing to what it meant to our doctor, but the detailed description of what our doctor did (rather than called it) made perfect sense to that Tribunal member.

If you're examining someone in chief, you always want to get down to this level of granular detail, because that's what makes it feel like something really happened. Because this is the trick, we can't see what happened, but someone can make us feel that we can see it.

This might an appropriate time to show a video excerpt from the movie *My Cousin Vinny*. Vinny is the unlikely hero in this comedic courtroom drama, defending both his cousin and his cousin's friend who were mistakenly thought to have murdered a shopkeeper at a convenience store named the Sack of Suds.

Maybe there are some issues with the way he conducts his cross-examination. Maybe there are some issues with his courtroom manner. He could work on his manner, but in terms of his questioning, this is brilliant.

Now this is a cross examination, not an examination in chief, but I have an important insight for you; examination in chief is just cross examination done by you and not your opponent. The way that you ask the questions is different, but the level of precision, the degree of detail that you want in the answers is the same.

In both cases, what you primarily want is the facts that support a conclusion, not the conclusion itself.

Example four; My Cousin Vinny

Let's listen to the cross examination and then let's think how it would apply to a witness statement in Chief. It's brilliantly funny too.

https://www.youtube.com/watch?v=-qQQB4V8dG8

TRANSCRIPT;

Q: What are these pictures of?

A: My house and stuff. House and stuff.

Q: Now what is this brown stuff on the windows?

A: Dirt? Dirt.

Q: What is this rusty, dusty, dirty looking thing over your window?

A: Screen? A screen. It's a screen.

Q: And what are these really big things right in the middle of your view, from the window of your kitchen to the sack of suds. What do we call these big things?

A: Trees?

Q: Trees! That's right. Don't be afraid to shout them right out when you know now, what are these thousands of little things that are on trees?

A: Leaves. Leaves.

Q: Leaves! And these bushy things between the trees.

A: Bushes

Q: OK, so, Mr. Grant, you could positively identify the defendants for a moment of two seconds looking through this dirty window, this crud covered screen, these trees with all these leaves on them and I don't know, how many bushes?

A: Looks like five?

Q: Eh, eh, don't forget this one and this one.

A: Seven bushes.

Q; Seven bushes. What do you think? Is it possible you just saw two guys in a green convertible and not necessarily these two particular guys?

A: I suppose

A: I'm finished with this guy.

END TRANSCRIPT

So I personally prefer *"I've finished with this guy"* to *"that concludes the cross- examination"*. But on a more serious note, as well as being very funny, it's also actually a very capable cross-examination and a totally successful challenging of identification evidence.

We can see that what a cross-examination does is extract facts from a witness that, in another context could just as well be evidence in chief, but uses the facts from the other side's witness to support our narrative.

The method by which we obtain facts to support our conclusions in cross-examination is different to examination in chief, because we ask predominantly tight, closed questions in cross-examination, but the content of that evidence, granular facts, is the same.

If we put that proposition in reverse, that is, we want to use similar building blocks to those used in cross-examination to support our witness's narrative in their evidence in chief, if we wanted to say for instance;

"The patient couldn't possibly have seen me do this or that,"

then all we need is those same building blocks.

"*The patient couldn't see me"* is just the conclusion. That's useless. Why couldn't they have seen me?

We don't even need to say *"they couldn't see me"*. We just need to describe in detail the layout, and the obstacles between the patient and the doctor, clearly described, so that the Tribunal has a picture of the situation, and from that picture, can see that the patient could not see the doctor.

In other words, what we want in our evidence in chief is the granular details, not the conclusions. Not *"I was careful. I was very careful when I did this operation"*, but *"these are all the things I did during the operation that were careful"*. We don't even need to call them careful. We just need to describe what we did.

(iv) Leave out what is irrelevant

Now, apart from all this detail that we need to put in, there is one other critical thing, which is what we need to leave out.

The answer? Everything that's irrelevant. We need to leave it out, for two reasons. First, because it mucks up our story and distracts from the story we want to tell. But what is the second reason? It is because anything in the statement can be the subject of cross examination.

Example five; what can happen if you include irrelevant details

Here is a really good example from when I first came to the bar, back at a time when I was doing some personal injury work, and there were these things called arbitrations in the District Court, which were informal hearings for determining personal injury disputes, with a barrister acting as arbitrator.

I was representing an insurer in that matter, and the plaintiff was someone who was claiming they had been injured, and my insurer's driver was at fault. It was all about who had the green light coming into an intersection, and who had the red light. Exciting stuff.

The plaintiff had included an unnecessary detail in their statement and that detail was that at 5 o'clock in the morning they were going to the airport to drop a package off. This was totally irrelevant to the

issue of who had the green light, but it was in there, and it just sounded sneaky and odd. What did they mean, they're just dropping something off at the airport at 5 in the morning?

This is well before Uber eats, and they're just a person driving in their car. And so I started asking them questions about it and the other barrister jumped up and objected, saying it was irrelevant, to which I responded, *"it's in the witness statement, it's part of their evidence. I'm just testing it"*. The arbitrator agreed, so I persisted. The witness never gave an question that sounded vaguely plausible, and I believe we won that case basically because the witness sounded dodgy, even though we had no real evidence that they were dodgy, or that it was the other person who ran the red light. There is always the risk that irrelevant details will just give the other side something to pick on, so leave them out.

(v) Use photos and diagrams

Another thing to consider is whether you want to use photos or diagrams, because they feel real, and they're often very persuasive and very helpful and also easy to understand. You might, for instance, be able to show a photo that indicates that if everybody agrees that the doctor's door was open, and an issue is whether an assault occurred, that shows clearly a line of sight from reception to the doctor's room, and if that is used, that may be useful. The photo will show it in a more compelling way than simply saying that, the doctor's room can be seen from reception.

I'm reminded at this point of an immensely entertaining case that Lydia Kamaras and I had where we made use of a diagram that eventually involved a witness placing our doctor's chair outside the external window on the third floor of the building.

To put it mildly, it certainly did call into question this witness's recollection of the room.

So certainly photos and diagrams can be useful.

(vi) Use simple language

And then the final tip I have with respect to statements is use the simplest possible language. Do not

use formal language. It's tempting for us as lawyers to cloak ourselves in legal sounding wordsli, but don't. In our daily lives, for instance, we don't utilise anything, we just use it.

We don't want very complicated sentences because nobody can understand them. We get to the end of the sentence and we say, hang on a minute, what was at the start of the sentence? So keep the sentences and words short, and keep them clear.

If you're getting a feeling for the doctor's own use of words, make sure that you use their words because otherwise it's going to feel as though the statement did not come from them when they speak quite differently while being cross-examined. It'll just seem like the statement of somebody of else. All eyes will be on you.

Just one final thing, which is just my personal plea but does relate to this question of plain language. Please, I don't want anyone offering condolences. In every day conversation, I wouldn't generally say to someone *"my condolences for your loss"*, but in a recent inquest, every single statement prepared by the police said *"my condolences for your loss"*. Every single one.

If you're the family, what are you going to think? *"Did the doctor say that or did the police put that in the statement?"*

It's not always best for a doctor to say they are sorry to the family an inquest, but if your judgment is that it is appropriate, or the doctor particularly wants to, see if you can get the doctor to say something that feels real.

"I am so sorry that your son Matthew died."

"I am sorry that we were not able to save his life."

Something like that, that's, something that I would feel was real if I were the family.

Condolences seem very abstract and formal. Some kind of little puffy thing. Maybe this is a condolence, or maybe it's some little puffy thing. I don't know what it is. I do know if you say *"I am so sorry that your that your son Matthew died"*, I will feel you meant it. If you add *"I'm sorry that we were unable to save his*

life", I, as the family member, am glad you said that. I'm glad you're sorry, because I know *I'm* sorry, but I don't know that you're sorry.

You can reassure your doctor that they are not they are not admitting liability, and there is no risk to them. They are simply saying they are sorry. It cannot be used against them, but it can help the family, which in itself is both a help and a comfort to the doctor.

Thank you.

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