John Doe (by Litigation Friend Lucy James)

V

A NHS Foundation Trust

INSTRUCTING SOLICITOR

A solicitor

A legal firm

REPORT PREPARED BY:

Dr Girish Vaidya

MBBS, MD, MRCPsych,

MSc (Healthcare Leadership), MSc (Healthcare Analytics and Artificial Intelligence)

M.E.W.I (Member of Expert Witness Institute)

Consultant Child and Adolescent Psychiatrist

Parkhead Consultancy, 356 Ecclesall Road South, Sheffield S11 9PU

Tel: 0114 235 6258 / Mob: 0786 871 1976

Email: girishvaidya@psychreports.co.uk

SAMPLE REPORT

Contents

1. **Introduction**: 3
2. The Author: 3
3. **Summary of the case:** 5
4. Issues under consideration: 7
5. Response to questions in the Letter of Instructions: 8
6. Declaration: 12

SAMPLE REPORT

1. **Introduction**:

1.1. I have been instructed by A Legal Firm on behalf of their clients to undertake a report on breach of duty / causation in the care afforded to John Doe (DOB:).

1.2. In preparing this report, I had access to and relied on the following sources of information:

1.2.1. Trust SIRI (Serious Incident Requiring Investigation) report dated June 2019

1.2.2. Letter of notification dated xxx

1.2.3. Letter of complaint dated xxx

1.2.4. Letter withdrawing complaint dated xxx

1.2.5. Email of complaint dated xxx

1.2.6. Multidisciplinary healthcare records from A NHS Foundation Trust.

1.3. It is not the intention of this author to repeat information already available to Court except where it is relevant to his conclusions and recommendations.

1.4. This report is based on the information available to the author at the time of writing this report.

2. The Author:

2.1. I am a registered medical practitioner with the General Medical Council as a specialist in Child and Adolescent Psychiatry.

2.2. My professional role is in the assessment and management of complex emotional, behavioural and mental health problems in children and young people.

2.3. My medico-legal work involves working with the civil and criminal courts. I have worked in the medico-legal field for more than a decade and have completed approximately 30 reports in a year on average.

SAMPLE REPORT

2.4. In civil claims, I have worked with claimants and defendants alike in equal proportion.

2.5. I am asked to provide second opinions (by NHS Trusts and Local Authorities) on assessment and management of risk presented by violent behaviours in young people. I am also asked to advice on appropriate placements.

2.6. My professional work provides me with experience of working with young offenders in custody as well as in the community. It also provides me with similar experience of working with Looked After Children in the community as well as in secure settings.

2.7. I have a particular interest and experience in assessment of **ADHD (Attention Deficit Hyperactivity Disorder) and Autism Spectrum Disorder (ASD)** in young offenders and those in the care system. This is with particular reference to violence, sexualised behaviours and aggression. I also have a professional interest in Gaming Addiction as well as other technology related addictive behaviours (e.g. addiction to social media and online porn).

2.8. I have practised psychiatry since 1991. I hold an MD (Doctorate of Medicine) in Psychological Medicine from the University of Bombay. I am a member of the Royal College of Psychiatrists. I undertake regular professional development and am registered with the Royal College of Psychiatrists for the same.

2.9. I have trained as an Expert Witness with Bond Solon. I am also a member of the Expert Witness Institute.

2.10. I am regularly instructed as a Single Joint Expert in Care Proceedings and have been called upon to give evidence in Court.

2.11. I am approved under Section 12(2) of the Mental Health Act 1983 (as amended) as having special experience in the diagnosis and treatment of mental disorder.

SAMPLE REPORT

2.12. I have published articles on, amongst others, Stalking in Adolescence in mental health journals.

2.13. I am a Former Associate Medical Director for my NHS Trust and an Associate Clinical Director for our local CCG (Clinical Commissioning Group). I am currently the Clinical Lead for Yorkshire and Humber Operational Delivery Network (ODN) for Autism and Learning Disability. I was the Clinical Lead for Clinical Networks of NHS England / Improvement for Children and Young People's Mental Health for Yorkshire and Humber.

3. **Summary of the case:**

3.1. My instructing solicitor has proved a very good summary of the case chronology which is reproduced here rather than attempted to be improved upon.

3.2. Claimant has a complex psychiatric history, with documented self-harm from a young age after witnessing the domestic and emotional abuse of his mother by his father from birth to age 7. He is reportedly overly attached to his mother and experiences high levels of anxiety, which can turn to aggression, and as a result struggles to cope with daily life. He was diagnosed with Attention Deficit Hyperactivity Disorder ('ADHD') in 2011 and autistic traits were also noted, but following assessments conducted in 2009 and 2013, Trust found him to not meet the criteria for ASD.

3.3. Claimant was referred to Trust's Child and Adolescent Learning Difficulties Service for psychiatric assessment in 2015 because his mother was dissatisfied with the previous ASD assessments. Claimant was assessed by treating psychiatrist Dr Smith (the first and only occasion) on 20.05.15, who diagnosed attachment disorder and developmental trauma

SAMPLEREPORT

instead of ASD, but this was not accepted by the mother and resulted in her leaving the appointment abruptly.

3.4. It would appear this exchange led to tension between the mother and Dr Smith, with the latter forming the view that the majority of Claimant's problems were due to the mother's parenting skills. As a result, Dr Smith rejected mother's subsequent requests for a further ASD assessment and medication to help manage increasing anxiety and behavioural issues.

3.5. Mother accordingly sought a second opinion from a private psychiatrist in 2015, who confirmed the ASD diagnosis, but again Dr Smith disputed this and maintained her view that neither medication nor further assessment were required.

3.6. Claimant's condition deteriorated and he attended A&E with his mother on xxx (date) with a report of heightened anxiety around COVID-19 and self-harm. It was concluded there was no overt risk to Claimant or others at that time so he was discharged. However, mother was unable to deescalate his behaviour and contacted the First Response telephone line the following day because she felt he was in crisis and required urgent support.

3.7. Problems persisted over subsequent days with Claimant becoming fixated on religion, life and death, so Dr Smith agreed in conjunction with Claimant's Lead Care Provider to prescribe Promethazine Hydrochloride for 7-days on xxx (date). Claimant reportedly responded well to the medication, but no assessment or followup was arranged to consider the effectiveness of this.

3.8. Claimant was admitted to hospital (B NHS Foundation Trust, nonDefendant Trust) on xxxx after superficially cutting his forearm with a knife. He was assessed by a mental

SAMPLE REPORT

health practitioner on xxxx (date) when Claimant indicated he had no intention of ending his life, so it was concluded he had no mental health concerns that warranted him remaining in hospital. However, his behaviour escalated significantly over the following days including an attempt to throw himself out of a window, tying ligatures around his neck, verbalising that he wanted to kill himself, and the need for 4 security guards to restrain him, prompting a Consultant Paediatrician to detain him under section 5(2) of the Mental Health Act.

3.9. Dr Smith was requested to assess Claimant as a result of the above but she refused to do so or consider prescription of medication, instead asserting based on the previous assessment of xxxx (date) that Claimant was not experiencing a mental health presentation and that the hospital environment was the cause of his distress. She accordingly rescinded the section 5(2) and recommended discharge home, contrary to objections from the mother and other involved agencies, which was effected on 02.xx.xx (date) without any further psychiatric assessment.

3.10. *On 05.xx.xx (date), Claimant left the family home via a small window without his family being aware. Dashcam footage later confirmed Claimant intentionally stepped in front of a lorry on an A road. He was airlifted to hospital with suspected head and spinal injuries.*

3.11. The SIRI report states (page 7) '*He was airlifted to hospital with suspected head and spinal injuries, but after examination, was found to have only minor injuries, including a bump on his head and a haematoma on his side.*'

4. Issues under consideration:

SAMPLE REPORT

4.1. Breach of duty – particularly by the Consultant Child and Adolescent Psychiatrist involved in John's care.

4.2. Causation – that the above Breach of Duty contributed to John experiencing a lengthy period of time without management or treatment of ASD.

5. Response to questions in the Letter of Instructions:

5.1. ***To what extent you agree with the SIRI report findings***: I agree with the SIRI report findings.

5.2. ***If any breaches of duty are identified, what you consider Claimant's reasonable management should have been*****:** There are a number of areas where the Claimant's management could have been better.

5.2.1. ***Error in focus on diagnosis, not on distress***: There appears to be little, if any, focus on the distress of the child or the parent. Parental and child distress appears to have been ignored with a particular focus on parenting and parent blaming. This is despite fellow professionals within education (and a private autism assessment) also identifying the presence of autism and the accompanying presentation that can be identified as that of autism.

5.2.2. ***Neglect of scientific evidence***: John was already diagnosed with ADHD. There is overwhelming evidence[1] of co-morbidity of ADHD and Autism with an acknowledgement that the **symptoms are more severe** in such comorbid conditions.

[1] Jina Jang et al., 'Rates of Comorbid Symptoms in Children with ASD, ADHD, and Comorbid ASD and ADHD', *Research in Developmental Disabilities* 34, no. 8 (1 August 2013): 2369–78, https://doi.org/10.1016/j.ridd.2013.04.021.

SAMPLE REPORT

Antshel and colleagues[2], in their update quote '*some researchers, using latent class analyses, assert that while ADHD symptoms occur without ASD symptoms, ASD symptoms do not occur without ADHD symptoms*'.

5.2.3. ***Medication as symptom management, not 'disease' management***: Psychiatric medications (similar to many other non-infectious disease management medications – e.g. Hypertension, diabetes, autoimmune conditions) target '*symptoms'* and are '*disease'* agnostic. Indeed, the prescription of Phenargan was itself for symptom control. As such, it would have been prudent to target the anxiety symptoms which would have ameliorated the severity of the anxiety that John was managing by himself. A number of fellow professionals seem to be pleading with the psychiatrist to consider medication which was turned down without any re-assessment or justification. The focus on parenting and attachment disorder (as a concept) seems to have prevailed over a pragmatic medication trial.

5.2.4. ***Failure to undertake detailed assessment of the parent child interactions increasing bidirectional stress***: Whilst there is evidence of parent blaming, there appears to be no evidence of any attempt to understand the bi-directional impact of a child's neurodisability on parental stress. There is now accumulated evidence that parents of children with neurodisability experience considerable stress which, in turn, can affect their parenting. Miranda and colleagues[3], in particular, emphasise '*The ADHD group obtained higher levels of parenting stress related to attachment and depression than did the other groups'.* For a boy feeling 'sinful' and perceptive of his

[2] Kevin M. Antshel et al., 'An Update on the Comorbidity of ADHD and ASD: A Focus on Clinical Management', *Expert Review of Neurotherapeutics* 16, no. 3 (2016): 279–93.
[3] Ana Miranda et al., 'Parenting Stress in Families of Children with Autism Spectrum Disorder and ADHD', *Exceptional Children* 82, no. 1 (1 October 2015): 81–95, https://doi.org/10.1177/0014402915585479.

SAMPLE REPORT

behaviour affecting his mother (note John asking his mother if she was OK) and yet unable to get the painful thoughts out of his mind – a serious attempt at self-harm (with the possible expectation of a fatal outcome) remained his only recourse when no further help was forthcoming.

5.2.5. ***Respite vs threats of child protection***: Whilst there was common acknowledgement of the pressure that John's mother was under and also an acknowledgement that his distress was persistent (and escalating), no thought appears to have been given to identify a respite placement – even for a brief period – for John. This would have been in the domain of social services. It would have offered another perspective on John's behaviours and would have helped further confirm the diagnosis of ASD. Threats from social care '*Social Care reiterated that if John's mother refused to take John home, her actions would be classed as abandonment and Child Protection procedures would be implemented*' (page 28 of the SIRI report) reflect poorly on their understanding of parental distress. There also appears to be a lack of overall appreciation of the impact of children with ADHD on families[4].

5.2.6. ***ADHD symptom control, impulsivity and 'stickiness of thought'***: Documentary evidence does not provide an idea of the level of symptom control of John's ADHD. Children with co-morbid ADHD and (undiagnosed, but present) ASD present a peculiar challenge to the treating clinician. The distractibility of the untreated ADHD often helps the child in avoiding dwelling on painful subject matters. With better symptom control, recall of past events – particularly traumatic events – becomes more

[4] V. A. Harpin, 'The Effect of ADHD on the Life of an Individual, Their Family, and Community from Preschool to Adult Life', *Archives of Disease in Childhood* 90, no. suppl 1 (1 February 2005): i2–7, https://doi.org/10.1136/adc.2004.059006.

SAMPLE REPORT

prominent due to the child's ability to string their thoughts together – for longer (which I have termed the stickiness of thought). This often leads to painful memories having to be addressed by the child with support from the treating team – specifically where there is history of or evidence of early trauma. Little attention appears to have been paid to this aspect of ADHD treatment and its correlation with his escalating concerns about being a sinner. In that context the SIRI report's mention of John's voice being unheard throughout is very pertinent. Another aspect of care – in relation to ADHD management – is the role of ADHD itself in increasing the risk of self-harming behaviours[5]. There is insufficient evidence to suggest that this had been explored in the communications between the various services addressing the issue of ADHD. Clinically, it is well known that impulsivity within the ADHD domain can increase the risk of fatal self-harm.

5.3. ***Whether reasonable management would have changed the outcome in terms of claimant's current psychiatric condition and prognosis and/or avoided the suicide attempt on 05.06.22, on the balance of probabilities.*** I don't have sufficient information to suggest any change in prognosis. However, a **comprehensive** psychiatric assessment of John's presentation and a scientific understanding of the factors that have predisposed, precipitated and perpetuated his distress would have ***definitely*** avoided the suicide attempt.

[5] Clare S. Allely, 'The Association of ADHD Symptoms to Self-Harm Behaviours: A Systematic PRISMA Review', *BMC Psychiatry* 14, no. 1 (7 May 2014): 133, https://doi.org/10.1186/1471-244X-14-133.

SAMPLE REPORT

6. Declaration:

I, Dr Girish Vaidya, declare that:

6.1. I understand my duty to the court and have complied and will continue to comply with that duty

6.2. I confirm that I:

(a) have no conflict of interest of any kind, other than any conflict disclosed in my report;

(b) do not consider that any interest disclosed affects my suitability as an expert witness on any issue on which I have given evidence;

(c) will advise the instructing party if, between the date of my report and the final hearing, there is any change in circumstances which affects my answers to (a) or (b) above;

(d) am aware of the requirements of Part 35 and practice direction 35, this protocol and the practice direction on pre-action conduct.

6.3. I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Dr Girish Vaidya Date:
Consultant Child and Adolescent Psychiatrist

SAMPLE REPORT