Case No: E58YX759

IN THE KINGSTON UPON HULL COUNTY COURT

Before:

His Honour Judge Cooper

Between:

THOMAS VINEGRAD (by his father and Litigation Friend MICHAEL VINEGRAD)	Claimant
- and-	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	First Defendant
and	
HULL & EAST YORKSHIRE HOSPITAL NHS FOUNDATION TRUST	**Second Defendant**
and	
HUMBER NHS FOUNDATION TRUST	**Third Defendant**

Mr Hugh Rimmer (instructed by Messrs **Coles Miller)** for the **Claimant**
Mr Quintin Fraser (instructed by Messrs **Hempsons)** for the **Defendants**

Hearing dates: 27th October 2020 to 30th October 2020

JUDGMENT

Introduction

1. This claim is brought by Mr Thomas Vinegrad, by his father and litigation friend Mr Michael Vinegrad. He seeks damages as a consequence of what he says was the negligence of the Defendants due to their failure to identify, diagnose or manage his severe brain injury and post-traumatic psychosis, which resulted in an acute mental breakdown in May 2013, and subsequent need for inpatient psychiatric treatment.

2. The trial took place over four days from the 27th October to 30th October 2020 inclusive. When listed the original time estimate was one of six days to include an element of reading time. For reasons that I am still unclear about the time available for the trial reduced to four days. There were clear and obvious time pressures as a result. I therefore convened a Pre-Trial Review with both counsel and discussed the impact of the reduction to include whether or not the trial needed to be delayed given that there was a real risk that it would not finish and would go part heard.

3. The outcome of the discussions was that I would press on with the hearing. Counsel were optimistic that we would be able to complete at least the evidence and submissions. I therefore decided that it was the best use of the Court's already allotted time to proceed but, on the sirid uuuca star1di1ig, that judg;.11cut ,T..ight be signifi.(:antly delayed if c01..l!''1sel's optimism did not bear fruit.

4. As it transpired and through no fault of anybody, only the evidence was completed by the end of the fourth day. I allowed counsel a week to send me their written submissions and said that I would reconvene the hearing for the purpose of judgment when I could. Again, I made it clear that due to the pressure on my diary that was very likely to be in 2021. All parties agreed with and understood that approach. Unfo1iunately, due to those time pressures it has not been possible to arrange a hearing within a reasonable timeframe. That was to my mind unfair on the parties and I have therefore handed my decision down in writing to help save further delay.

5. I should for the purpose of this judgment make clear that the whole of the trial was dealt with remotely over Microsoft Teams with no physical presence in the Court building. That was of course due to the present national health crisis. I thank and commend the respective legal teams for their help in conducting the case in this format. It was not easy

and was very tiring. I was careful to build in effective breaks to give everybody downtime from their computer screens but do not underestimate the impact that the process had on all concerned.

6. I should also at this stage extend particular thanks to both Mr Rimmer and Mr Fraser counsel for both parties. It was readily apparent to me from the date of the Pre-Trial Review that they had worked incredibly hard to agree as much as they could do in advance of the trial and to ensure that the bundles (there were two to include a separate Medical Records bundle) were in a fonnat that was easily navigated and so helped everybody focus on the core issues. That assistance continued throughout the trial. Both worked together and helped one another by screen sharing relevant documents when their opponent was cross examining a witness. Neither could have done any more to fully and properly present their client's case or to assist the Court.

The Background

7. This is well understood but briefly, on 14th August 2012 Thomas suffered serious injuries after being struck by a car whilst working overseas in China. Those injuries included nasty orthopaedic injuries and a serious head injury. He was unconscious for a week, intubated and ventilated in a hospital in China. Once Thomas was medically stable he travelled back to the United Kingdom accompanied by his sister who had travelled to China to be with him.

8. On arrival in this country Thomas attended the Accident & Emergency department at the University College Hospital (UCL) in London. An assessment was carried out including a CT scan, which excluded the need for any immediate or acute neurosurgical intervention. A referral to clinical services nearer to Thomas's home was considered to be the appropriate next step and staff at UCL spoke with the neurosurgical team at the Hull Royal Infirmary (HRI), Thomas lived in the Hull area with his family, who confirmed that they would arrange an appointment for him.

9. Unfortunately, no appointment was provided, and that referral did not occur. HRI is under the control of the Second Defendant, the Hull and East Yorkshire Hospital NHS Foundation Trust. They admit that the failure to provide that appointment was a breach of duty. Pausing there a claim was also brought against the Trust responsible for UCL,

named as the First Defendant. Sensibly and in the interests of simplifying the issues, the case against the First Defendant has been discontinued.

10. During the period that he was waiting for the expected neurology appointment, and due to concerns over behavioural and personality changes, Thomas was referred by his General Practitioner for a mental health assessment at the Single Point of Access for Assessment (SPA). That refe1Tal was under the control of the Third Defendant, the Humber NHS Foundation Trust. Following that referral the SPA discharged Thomas giving advice that he should wait for the neurology appointment from the HRI, who could then refer him for psychological services should they think that such a referral was necessary.

11. Time passed and no appointment was received from the Second Defendant prompting Thomas's General Practitioner to request a referral to neurosurgery at the HRI. On 4th February 2013 a Consultant Neurosurgeon at the HRI, Mr Morris, wrote to the General Practitioner confirming that at that stage, which was by then almost six months post-injury, Thomas did not have an acute neurosurgical problem **[204 MR].** There was an onward referral to the Second Defendants' neurological rehabilitation clinic , the Post-Traumatic Concussion Clinic (PTCC). To be clear, no allegations of breach of duty are pursued against Mr Morris.

12. Thomas was seen on 22nd March 2013 at the PTCC by Dr Humphreys. No physical rehabilitation needs were identified but, due to changes in his personality and levels of anger, he was referred for assessment by a neu ropsychologist, to be followed up and reviewed at the PTCC in six months. Although there exist criticisms about the content and outcome of this appointment, in the interests of narrowing the core issues the Claimant pursued no allegations against the PTCC or Dr Humphreys at trial.

13. Sadly on 8th May 2013, and before any assessment or follow-up could occur, Thomas suffered an acute psychotic breakdown. After visiting a friend in Basingstoke , he was found walking barefoot in the middle of the night in Basingstoke shouting and banging on walls and claiming amongst other things that there was a *"second coming"*.

14. Mr and Mrs Vinegrad brought Thomas back to Hull and took him to the Accident and Emergency department at the HRI. He was detained under section 2 of the Mental Health

Act 1983 and admitted for inpatient psychiatric care for a period that exceeded six months, before being transferred to a brain injury rehabilitation unit in late 2013.

The Claim

15. The basis of the claim is neatly summarised 1n the skeleton argument of Mr Rimmer. In the absence of the admitted breach by the Second Defendant of the failure to arrange for treatment in Hull, and/or the alleged breaches of the Third Defendant in October 2012 Thomas would have had:
    a) Proper assessment and monitoring of his condition , which would have resulted in the appreciation of the extent and seriousness of brain injury and psychiatric complications, with his deteriorating personality and behavioural issues identified;
    b) He would have been seen by a psychiatrist with a recommendation that he take an antipsychotic medication (probably Olanzapine);
    c) It is likely that the Claimant would have taken this medication , and it would have prevented the florid psychotic symptoms and breakdown that occurred in May 2013. He would then have avoided the period of inpatient psychiatric treatment between May and November 2013.

16. On the issues that remain between the paiiies (which are dealt with below) the claim is fully defended.

Representation

17. As already indicated Thomas was represented by Mr Rimmer and the Defendants by Mr Fraser, both of counsel.

Evidence

18. P1ior to the hearing I read the relevant documents in the bundles. When I refer to documents from either bundle they appear with the page number followed by "TB" (trial bundle) or "MR" (medical records bundle) as follows **[xx TB]** or **[xx MR].** In addition I have read the helpful skeleton arguments prepared by both counsel, the list of core issues, the chronology and as already indicated, I have also now received and read the respective closing submissions,

19. I heard oral evidence from Mr Michael Vinegrad and Mrs Anita Vinegrad Thomas's parents and Miss Kim Vinegrad his sister.

20. I heard oral evidence from the following experts Professor Al-Din , and Dr Mumford Consultant Neurologists (for the Claimant and Defendant respectively), Dr Harris and Dr Landham Consultants in Neuro-Rehabilitation medicine , and Dr Mahapatra and Dr Friedman Consultant Psychiatrists.

The Issues that remain to be determined

21. As mentioned earlier counsel worked hard to narrow the issues. Concessions were made where appropriate leaving a definitive set of core issues for consideration. I will deal with each issue in turn.

What symptoms did the Claimant exhibit between August 2012 and May 2013?

22. To be able to assess what referrals or treatment Thomas ought to have had it is necessary to establish what symptoms he did or would have presented with between August 2012 and May 2013. It is the Claimant ' s position that consideration of the medical records alongside the evidence from the lay witnesses allows the Court to be able to determine those symptoms.

23. The Defendants accept that prior to May 2013 Thomas was exhibiting a number of **sy1r1pto111s for w·hich treatinent vvas sought. Ho\.vever they say tl1at the ,.rast majority of** those symptoms arose as a result of his traumatic brain injury. Specifically where the various lay witnesses suggest that Thomas was exhibiting symptoms which are not recorded in the medical notes and records which are contemporaneous documents, those documents should be viewed as being more reliable given their nature.

24. Mr Rimmer summarises the concerns that Thomas's parents had about his behaviour in his skeleton argument as follows; he was bad tempered and irritable, did not recognise danger, had unusual food preferences and was over-eating, was fixated on religion, had an obsessional use of the internet both during the day and night and had obsessive thoughts and demonstrated repetitive behaviour.

25. In his witness statement at paragraph 11 **(92 TB]** Mr Vinegrad explained that Thomas had had issues with depression previously. He said this, *" Prior to the RTA and the head injury in question Thomas had never been diagnosed with psychotic condition including schizophrenia, bipolar disorder or otherwise. His symptoms appeared to be a reaction to life stresses including exam pressure. Thomas 's behaviour otherwise was balanced and what you would consider to be normal for a young man of his age".*

26. At paragraph 9 of the same statement he explained that, *"In 2009 Thomas was hospitalised after taking an overdose of paracetamol whilst at university. He was*

diagnosed with depression and was referred to counselling at the crisis resolution of the community mental health group. We were informed by mental health services that this was most likely a reaction to my wife and I splitting up, the stress of university studies and having been made redundant from his evening job at University. This was a distressing time for our family".

27. Following the accident, Thomas returned to live in Hull. Mr Vinegrad described in his statement at paragraph 33 that *"his behaviour had changed a lot and he suffered from terrible mood swings and dietary issues".*

28. He continued, *"following our return to Hull the family all noticed that Thomas 's personality and behaviour seemed to have changed considerably. He was very bad tempered, irritable and did not recognise danger, kept eating and had very unusual food preferences for example eating beans on toast together with chocolate cake. He became fixated on religion and stayed up very late on his computer".*

29. Further at paragraph 35 he said, *"Thomas had obsessive thoughts about homophobic behaviour and stereotyping of people and being extremely philosophical. This was quite out of character for Thomas",* he continued at paragraph 36 that, *"we also noticed that Thomas developed very repetitive behaviour and his speech was much slower and slurred than previously".* At paragraph 37 he said *"Thomas became very paranoid obsessive and forgeiful. We noticed that Thomas had become very weak indeed, was very slow and appeared unwell. Often he required the use of a wheelchair".*

30. When giving his oral evidence Mr Vinegrad was measured. It was clear to me that he had been through a great deal and that on occasions answering some of the questions was a very emotive and painful experience for him. He dealt with the "ordeal" with considerable dignity. On occasions he struggled to recall specific issues and facts but was not afraid to say so. He was, I have no doubt, an honest man doing his best to recall all that had happened against that very emotive and personal background.

31. Mrs Anita Vinegrad in her statement recalled the difficulties that Thomas experienced following the breakdown of her marriage from his father, the fact that he had lost a job whilst at university and that they feared he was being groomed by a man living in the same property as Thomas. At paragraph 11 of her statement **(104 TB]** she said this *"from*

my mind he had no mental health issues whatsoever prior to the accident in China, other than the confusion and despair brought on by a domino effect of circumstances. Like many young men these days he internalised everything. The attempted suicide which I feel was really a desperate cry for help. It was not as a result of schizophrenia or any other psychotic condition".

32. When he was at UCL in London having returned from China Mrs Vinegrad recalled that *"Thomas was very quiet and eating insatiably and would not stop. We had to keep feeding him weird mixtures and combinations".*

33. On their return to Hull following a stop at his sisters' in Leeds Mrs Vinegrad recalled the following, *"we had to bathe him by hand and also keep up with the bizarre set of behaviours. For example, an insatiable appetite for foods like chocolate pudding followed by beans on toast. He would only eat at one little cafe on the corner, it was like a ritual".* At paragraph 26 of her statement she sets out the following *"then there was a problem with him being on the Internet virtually all day and a lot of the night. He sent hundreds of bizarre messages to people and when he was not doing that he was on his mobile phone to his friend Harvey or anyone who would listen, but the time he spent on his laptop and phone was completely off the scale".* And at paragraph 27 she said this *"it was obvious to us that Thomas 's behaviour was obsessional and nothing was normal. My sister and brother-in-law, both retired teachers, were involved at this point and we were all concerned about the non-stop messages on the laptop and all bizarre running maybe into over 1000 over time".*

34. Mrs Vinegrad was asked by Mr Fraser about the incident in Basingstoke. She recalled that he came home to the HRI and that he was *"screaming at the hospital and screaming at me".* She was asked when Thomas was screaming about female genital mutilation whether or not he had raised or spoken about that before. She replied *" never".* Her explanation for him talking about female genital mutilation was that Thomas had done *"Russian history. He was a caring person. He had seen it all with Russian history. He was upset. It was sad really".* I have no doubt that Mrs Vinegrad was an honest witness but she presented as being stressed, her evidence was not easy to follow and at times was confusing.

35. She said that after the breakdown in Basingstoke Thomas on the way home was, *"ranting all the way in the car. Prior to that rant he had never spoken about anything like that"* (meaning female genital mutilation). Mr Fraser questioned Mrs Vinegrad about this further and particularly paragraph 34 of her witness statement where she says, *"Thomas 's behaviour was obsessive in particular he was obsessed with his religious mission and the horror of female genital mutilation. He was obsessed with China and he would talk to strangers and walk ahead as if we were not there".* Mrs Vinegrad confirmed that it was only in the car on the way back from Basingstoke that Thomas ranted about female genital mutilation. She confinned that paragraph 34 and the behaviour referred to in that part of her statement, occurred during May 2013 and after Basingstoke.

36. Mrs Vinegrad's oral evidence contradicted her written evidence. Paragraph 34, referred to above, appears in the section of her witness statement headed *"Return to Hull September 2012 to April 2013".* Given her oral evidence I am satisfied that Mrs Vinegrad must have been wrong in her witness statement about the time when she recalled Thomas's behaviour to become obsessive and made his references to female genital mutilation and other obsessions.

37. When she was asked if and how this had all had a profound effect on Thomas she gave a very strange answer. She referred to Charles Dickens writing novels and that an intelligent person would see what was wrong. I confess that I struggled to understand that answer. She was asked whether or not Thomas had become aware of man's inhumanity and if that had had a profound effect on him. She said that she thought so because it was a part of his make up to be sensitive. She did not know if he was reading about Russian history prior to going to China.

38. It is common ground that Thomas went to Scotland before he went to China. We know that when he went to Scotland that he had been prescribed antipsychotic medicine. Mrs Vinegrad was asked if Thomas had suffered any episodes whilst in Scotland and replied that there were no episodes at all. She was asked about the prescription of antipsychotic medication (when Thomas was in Scotland). She said, *"no not to my knowledge no they were very straitlaced people who took him, if there were any problems they would not have had him".*

39. Mrs Vinegrad reflected on the time surrounding Thomas's breakdown in May 2013. At paragraph 42 of her witness statement she said this, *"Michael and I went to Basingstoke to fetch Thomas. Harvey and his landlord were in his flat when we got there. The landlord told us that Thomas had sexually propositioned him. This was when the inappropriate behaviour seemed to manifest even though it had already been an issue in Italy. After Basingstoke we saw much more of the danger that Thomas had become to himself and maybe others".*

40. Mr Fraser asked her about that paragraph and suggested that the first time that inappropriate behaviour such as that was exhibited by Thomas was when he was in Basingstoke or in Italy. She answered, *"yes I suppose so".*

41. There were other inconsistencies between Mrs Vinegrad's oral and written evidence. She confirmed that Thomas had travelled to Turkey on two occasions. He went in 2015 and 2018 which of course were both after the breakdown in Basingstoke. She confinned that Thomas was in Turkey when he sent them Muslim prayer mats at Christmas. That contradicts paragraph 29 of her witnc33 3tatement where she said, *"Thomas started shouting religious thoughts and had an idea that he was going to go back to China and sort out the Chinese. At Christmas 2012 whilst we were all at Kim's Thomas had sent us nil presents and when opened were Muslim prayer mats. This was completely out of character".*

42. The point of course is that Thomas was not in Turkey at Christmas 2012. Mrs Vinegrad was not persuasive when she was questioned about that inconsistency. She said that she did not know where Thomas was and that she could not remember what year it was. She was pressed further on the point and was asked whether she was confident that the incident with the prayer mats was before or after the breakdown in Basingstoke. She answered that it was after Basingstoke which of course means that she could not have been right when she reflected that Thomas had sent the prayer mats in 2012 and was exhibiting that behaviour at that time.

43. When the inconsistency was put to her again she became defensive suggesting that she had *"no idea, not a clue".* She was however very clear that when Thomas was shouting out religious thoughts and threatening to sort out the Chinese that that was after the Basingstoke breakdown and not before.

44. Miss Kim Vinegrad in her witness statement said at paragraph 8 **[117 TB],** *"the mental health problems Thomas suffered whilst at university were very different to the ones that he suffered following his brain injury. Thomas 's behaviour after his brain injury in China was completely different. He was effectively childlike and his personality had changed'.*

45. Miss Vinegrad travelled to China to be with her brother after the accident. She explained at paragraph 16 that on her arrival Thomas did not know who she was. She said, *"Thomas was extremely disorientated and his personality had completely changed. He had an insatiable appetite and was literally going to eat of my hand and getting food out of the bag. He did not seem to know when he was fitll".*

46. She continued at paragraph 17 that, *"Thomas had no concept of pain. Although he had suffered a fractured pelvis, arm and head injury he kept trying to get out of bed and walk. At that stage we did not know the extent of his head injury but were informed that he had a bleed on the brain which was the main issue".*

47. Miss Vinegrad explained in her witness statement how the follow-up to include an MRI scan at the HRI never happened. She describes at paragraph 26 of having to fight *"tooth and nail for the MRI scan to be carried out many months later, by which time it was too late as Thomas had deteriorated so much. I just knew from his significantly altered behaviour from the outset that the extent of the brain injury needed investigation and clearly needed support".* She continued to say that the family were unaware of the extent of Thomas's brain injury for a long time probably until after his breakdown in May 2013.

48. Once Thomas had returned to Hull Miss Vinegrad described how Thomas had changed. At paragraph 30 of her statement she said this, *"Thomas became quite paranoid and thought that people were watching him. He was aware of this and questioned his own sexuality. This led to him feeling quite insecure, frustrated and fuelled his anger".* She went on to explain how Thomas became more and more childlike, difficult to handle or reason with and how he developed tantrums and became aggressive and angry and that Thomas would not acknowledge that there was anything wrong with him or that his behaviour had changed in any way.

49. She explained that as a consequence of his behaviour Thomas went to live with her in Leeds for a while. She described his tantrums as being *"alarming".* At paragraph 36 of

her state ment she said this, *" I knew things were not right and deteriorating quite significantly after the events that occurred in Italy. I tried to help him following his return explaining to him that he was very unwell but he would not accept this and became very aggressive and angry. Thomas sent me thousands of texts saying that I was a bad sister. This was distressing, however, I got used to it in the end and I knew that it was because of the injuries suffered in the accident"* . She explains at paragraph 37 that *"there was always the same pattern of behaviour, aggressi ve, defensive then angry and throwing a tantrum or a meltdown"*.

50. Miss Vinegrad was an impressiv e witness. She was clear and thoughtful. She did not avoid answering any questions and did her best to explain the problems and difficuities that she recalled that her brother had had. She was asked by Mr Fraser about Thomas's early mental health issues. She was clear that he suffered from acute depression brought on by their parents' divorce, and their grandmother dying. She said that Thomas was *"not psychotic"*. She was asked whether or not she was aware of any psychotic symptoms prior to Thomas ' s issues with his mental health she was very clear she said, *"not at all, depression yes psychosis no"*.

51. She expanded upon the symptoms that her brother had suffered following the accident. She explained that he had never been an angry person before. She identified that he had no inhibitions he did not feel any pain and his appetite changed in a bizarre manner. She described him as eating backwards in that he would have a sweet first rather than a savoury dish and that he had become very animalistic.

52. When asked whether Thomas, prior to his going to Italy, had suffered with any delusions she confirmed that he had not. She said that she was not aware of him exhibiting any sexually inappropriate behaviour. She explained that when the issues emerged in relation to how Thomas was viewing sexual issues whilst in Italy that she was *" horrified"* and that *"it was obvious that he was not well he should not have gone to Italy. We all thought that"*. She explained how she had tried to stop him travelling to Italy but that he was a grown man and that he wanted to go back to China also.

53. She was asked about Thomas's deterioration. She said that when they came back from China he could not do anything for himself. She remembered that roundabout December 2012 he became aggressive. She recalled that he was not bad tempered but that he got

very frustrated he could not understand why he was frustrated and he did not recall what had happened to him. She explained that Thomas had never been an aggressive person previously. She described it as *"like having a new brother"* from the one that she had had before he went to China.

54. Mr Fraser asked her about the deterioration after Thomas's visit to Italy. He asked whether or not she was saying that the deterioration was slow in January, February and March 2013 and then became more sudden in May 2013. Her answer was *"no, he obviously had a psychosis in Italy. When he lived with me he was showing signs. He was very childlike. I would not have trusted him to have gone into Leeds on his own. Nobody wanted him to go. The psychosis happened in Italy. There was not a big build up happening beforehand"*.

55. As already indicated I have absolutely no doubt that all of the family members who gave evidence were being honest and doing their best to recount events as they personally· recalled them. I am however mindful that the key events to which they spoke occurred seven or eight years ago and some longer long that. Mr Fraser in his closing submissions referred me to the decision in ***Gestmin*** and to the complications associated with a Court detennining facts in relation to testimony based on memory, and as set out by Leggatt J (as he then was). There is no need to recite all of the relevant parts of that judgment but in paragraphs 15 and 16 he said this: *"An obvious difficulty which affects allegations and oral evidence based on recollection of events which occurred several years ago is the unreliability of human memory. While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other people's memories are unreliable and believe our memories to be more faithfitl than they are. Two common (and related) errors are to suppose: (I) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate"*. I bear that in mind when assessing the wide canvass of the available evidence in this case.

56. It is necessary to consider the contents of the contemporaneous medical notes and records in conjunction with the evidence of the witnesses referred to above. Due to the concerns his family had about him Thomas was referred to his General Practitioner who decided to refer Thomas to the Single Point of Access and did so by way of a letter dated 20th September 2012 **[170 MR].** That letter records *"Thomas is experiencing a lot of behavioural changes, he is living with his parents who are obsen1ing him all the time and think his behaviour has completely changed. His mood and speech are different and he is also developing repetitive behaviour".*

57. That referral led to an assessment at the Single Point of Access under the control of the Third Defendants. The assessment is found at **[183 to 191 MR].** The assessment was can-ied out by Nurse Rusling, a specialist nurse with mental health services, on 16th October 2012, and the assessment was sent to Thomas's General Practitioner on 19th October 2012.

58. Within the assessment is a section entitled *"Insight: degree of understanding of ones own problems and the need for treatment".* The notes record *"Good level of insight Tom is fully aware of the problems caused by the accident and that this affects his cognitions within a slowing process Tom is able to manage daily activities and socialises with friP.nd,;; with the help of his father. Tom is aware that he is ruminatinf< on thoughts which were around prior to him going to China He would like to talk engage with a male worker as he would find this easier. Tom has future plans this was evident throughout the assessment and he has no reported to wanting to commit suicide".*

59. The notes make clear that Thomas was accompanied to the assessment by his parents but that Thomas did not want them to accompany him in the interview. However the letter to the General Practitioner records *"I was able to speak to Mr Vinegrad at the end of the assessment as Tom gave permission to gain his parents view of the present situation and of his current mental health needs".*

60. In the assessment there is a section which makes it clear that Nurse Rusling did speak with Thomas's father the relevant passage **[140 MR]** says this, *''father came into the assessment at the end when Thomas agreed that his father and not his mother should be present to offer further information relevant to the assessment. Mr Vinegrad reported that Tom had lived with him in Hull and an incident occurred with a friend of Tom's, Harvey*

whom Tom was very close to. He left suddenly which affected Tom. Mr Vinegrad briefly spoke about Tom and his ruminations on sexuality and reported that Tom is aware of where he is with this. Mr Vinegrad reported that Tom was nai·ve about life and things that happened in China. Mr Vinegrad reported that Tom's physical health is improving and there is also an improvement with the concussion although there is still improvement to be made."

61. The note continues, *"Mr Vinegrad is aware that Tom is going over issues about sexuality and the gay-rights talking about people's reactions and projections onto others. Tom is spending a lot of time on Facebook he has talked about volunteering to work in a charity shop of which Tom confirmed and was positive about looking into this. Tom wants to get back to routine dad takes Tom out and about. Mr Vinegrad reported no concerns over Tom's mental health NO EVIDENCE OF ANGER IRRITABILITY NO REPORTED "STRANGE" "ODD THOUGHTS" NO CONCENRNS ABOUT ANY RISK BEHAVIOURS Tom often reflects and ruminates on the Meaning of Life"*

62. The assessment continues under the heading *"Formulation"* as follows, *"Tom has found it difficult to return to Hessle to live with his parents who are divorced and have their own problems. Tom reports that they are always watching him. Having spoken to Tom's father as Tom requested that I speak to him at the end of the assessment Mr Vinegrad had no concerns about his son's physical or mental health and has been active and encouraging in Tom socialising with his friend to help the current situation which is not ideal."*

63. The assessment continues in the same paragraph, *"in January 2011, was seen by the team at Beverley including Julie Moore she identified the psychological problems at that time as being linked to the trauma he had experienced over the past few years it would appear that Tom's presentation is similar to that in 2011 with recent traumatic events affecting his psychological well-being and associated ruminating cognitions which would appear to be focused on sexuality. I have spoken with Dr Harkness regarding the assessment and it was his opinion that Tom should attend the neurology appointment which will indicate the need for input from psychological services if appropriate".*

64. It is also clear from reading that assessment that Mrs Vinegrad was not happy that she had not been allowed into the consultation, the notes show that she was eventually asked to leave the building. I can understand why Mrs Vinegrad was upset that she could not be

included but of course patient confidentiality was paramount. However, the note does help identify some conflict and difference of opinion between herself, Mr Vinegrad and Thomas.

65. Thomas was seen at a follow up assessment at the request of Nurse Rusling on the 29th October 2012. He was seen by Cedric Illidge the outcome of that appointment is seen in a letter by Nurse Illidge to Thomas's General Practitioner **[192 MR j.** That records that Thomas *"presented as relaxed"* and that was because he had been away from the home envirorm1ent for a few days and that he *"finds it difficult living in the home environment"*. The letter continues that Thomas *"did not present with any thought blocking behaviours or appear to be responding to unseen stimuli. There were no signs of acute mental health"*.

66. An entry on 27th December 2012 records *"mother concerned about his mental state, on Internet continuously, she said he told a friend last night that rta in China was a suicide attempt, then denied it later, wants him to have counselling, behaviour different since head injury, MRI due next week. Plan: see previous medical reviews, appears to be some family conflict about his condition"*.

67. The appointed experts were asked to consider this issue as far of course as their expertise would allow them to do so. The evidence of Dr Mahapatra and Dr Friedman demands analysis. Pausing there I have considered carefully the respective closing submissions of both counsel in respect of the psychiatric evidence. I am grateful to both for those submissions but make it clear that I arrived at my own assessment of both experts during the course of the trial. Both were subject to extensive cross-examination and to re-examination. I had ample opportunity to assess the quality and the consistency of their evidence.

68. Dr Mahapatra was the Claimant's appointed expert. I have little doubt that he is nothing other than a very experienced clinician. He was an extremely respectful and pleasant witness. However, he was a witness about whom I had concerns for a number of reasons.

69. Firstly, I detected throughout his evidence that Dr Mahapatra was being defensive as he sought to justify his opinion. That defensive approach led to what seemed to me to be a reluctance to answer what on the face of it were very straightforward questions. For

example, and I refer to this in greater detail below, he was quite unable or unwilling to accept that Dr Friedmans' opinion might have been within a range of reasonable responses in circumstances when that opinion differed from his own.

70. Secondly that defensive approach led to some rather circuitous and meandering answers to questions that were put to him by Mr Fraser in particular. Being blunt, on occasions I found it difficult to follow the logic of some of the answers that this expert gave.

71. Thirdly he presented as having very strong views as to how he saw NHS clinics operate despite the fact that he had not been in any such clinic for over twenty-five years. He referred to the process (within the NHS) as being *"totally diabolical"*. That troubled me as I was concerned as to his objectivity when considering the larger picture and his being able to offer opinion on the treatment or otherwise offered to Thomas. He had what appeared to me to be very fixed views. I am satisfied that he did not have present insight into the current workings of a busy NHS clinical department. He accepted that it was very rare for a traumatic brain injury to be dealt with in private practice.

72. Fourthly he was not aware of the test in **Bolam.** Nonnally I would not be concerned by an expert not being able to explain with clarity or precision a legal principle with which they are not perhaps totally familiar. Mr Rimmer in his closing submissions dealt with this on the basis that because there are no issues of breach of duty for me to decide this experts' inability to explain the test in Bolam should not trouble me. I understand that argument but for me it was a skilful attempt to deflect the underlying concern that the lack of knowledge of that test exhibited. In a case such as this a basic understanding of the legal principles by an expert is, to my mind, important particularly if they are going to express strong opinions as this expe1i did. Unfortunately, here it exhibited a complete lack of understanding of the process with which this case is involved. Dr Mahapatra said that *"I have never applied it myself'* (meaning the test) and then expanded by saying that it was *"hypothetically putting forward a notion and having to respond. I have heard of it, never applied it"*.

73. Fifthly and of concern, was that it became clear that this expert had not considered in any detail when writing his first report the underlying mental health records. That was a more than surprising omission. Further, when he prepared his second report dated 13th February 2019 he confirmed his previously held opinion that, *"after having considered*

the iriformation contained in the defence submission I wish to reaffirm the opinion I had expressed in my report of 2 May 2017 in the appropriating deficiencies in his care and treatment which had eventually resulted in him from suffering from florid psychotic illness caused by organic brain damage and for exposing himself to unwarranted danger when he was mentally disturbed".

74. There is specific reference to the Defence having been considered. Wnat is troubiing is that the Defence refers to extracts from the mental health records which this expert had not seen but despite that, and having said that he had read the contents of the Defence , he confinned his opinion but without again making any reference to those notes and records.

75. By comparison Dr Friedman was a very clear and impressive witness. He was consistent. He understood the legal tests and his duties as an expert. He was prepared when necessary to make concessions and to adjust his position when he felt it appropriate to do so.

76. I have in mind my assessments of these expert witnesses when considering this and the other issues in respect of which they were asked to provide an opinion.

77. In contrast to that of Dr Mahapatra it is evident from the rep01i of Dr Friedman that he had considered the Claimant's medical notes and records fully prior to and during the preparation of his report. Dr Friedman disagreed wifo ihe <.:urn.:lusiuus u[Di Maliapatrn iii. his original report. He said this **[241 TB],** *"I have also reviewed the report of Dr Mahapatra, consultant psychiatrist, of May 2017. I have significant concerns about the psychiatric report. I do not consider that Dr Mahapatra is a neuropsychiatrist or has had significant experience in thP- psychiatric management of traumatic brain injury. There is not a detailed review of the medical records. In particular, there is not a detailed review of his psychiatric symptoms and opinion about his psychiatric condition prior to the head injwy. There does not appear to be detailed review of all of his psychiatric symptoms over time. There were various meetings and assessments after his return to the UK and these do not appear to have been considered in detail in the psychiatric report. The report appears to assume that his subsequent psychotic psychiatric symptoms were related to and caused by the head injury (even though this is not supported by medical records)".*

78. It was notable that when the opinion of Dr Friedman, that Thomas suffered with bipolar, was put to Dr Mahapatra he would not accept initially that Dr Friedman's view was

within the range of reasonable opinion for an expert in that discipline. He was defensive. When it was put to him by Mr Fraser that Dr Friedman's view was a reasonable one he answered, *"I do not agree with him"* rather than perhaps conceding that Dr Friedman's opinion might have been within the range of reasonable opinion.

79. Mr Fraser tried again and asked Dr Mahapatra if he could agree that Dr Friedman seeing the psychiatric illness as a part of bipolar was reasonable. Rather than accepting that it was reasonable he said, *"anybody can put a diagnostic label on it, I do not agree with his diagnosis"*. He was pressed further on the point and asked whether or not despite disagreeing with Dr Friedman he thought that his opinion was a reasonable one. Dr Mahapatra's answer was meandering. To my mind it was one that was designed to avoid answe1ing something that might imply criticism of his own opinion. He said that it was *"reasonable on an individual basis but not on scrutiny of the evidence. I do not agree with the formulation. It is reasonable in the sense that a clinician is entitled to hold their own opinion"*. The difficulty for me with that answer is that it was not supported by him following scrutiny of the evidence. I have already said that it was clear to me that Dr Mahapatra had not read all of the relevant documents when fonnulating his opinion but that Dr Friedman had. Dr Mahapatra's criticisms of Dr Friedman were not strong, they were not well evidenced or structured.

80. Dr Friedman supports his diagnosis of bipolar as follows: *"I consider that the documentation clearly describes prodromal symptoms and, indeed, some symptoms that probably were psychotic prior to going to China. He was in remission due to medication and when he stopped this on his return from China, he gradually became more unwell, resulting in him becoming floridly psychotic in May 2013. I cannot find any evidence that he developed an organic psychosis due to his head injury, which would have been expected to present at the time of the traumatic brain injury or soon afterwards. The history clearly does not describe this and, indeed, he went to Italy to work as an au pair. His family were not significantly concerned about him at that time. The witness statements do not describe him developing a psychosis on his return from China or that there were any significant concerns about him going to Italy. I consider that the statements of the family describe neurocognitive changes and mild behavioural problems that are common after a traumatic brain injury. I consider from the contemporaneous documentation that he started to become more obviously psychotically unwell whilst in*

Italy leading on to his admission in the United Kingdom. This would be typical of somebody suffering from a psychotic illness such as bipolar disorder".

81. Dr Mahapatra in his report dated 2nd May 2017 states, at paragraph 30 **[209 TB]** as follows, *"the mental health assessment by the single-point access was not done until 16th of October 2012 and that no satisfactory support or help had been pianned on the basis of the assessment. There was compelling evidence that his behaviour was abnormal and he was preoccupied with matters relating to God and sexuality. He had displayed fixed conversation feeling that people were looking at him. He was reported to be slower in his thinking. He appeared to spend a considerable amount of time on Facebook. The behaviour problems and changes of mood were not indicative of his past psychiatric problems particularly with a history of head injury on 15 August 2012".*

82. Dr Mahapatra criticised the advice given to Thomas when he was seen on 16 th October 2012 because *"in the circumstances since he was showing signs of mental disturbance following severe head injury".* He continued at paragraph 31, *"I was firmly of the opinion that effective action of referring him to the acute psychiatric services at this stage would have averted Thomas suffering from serious post head injury psychosis which he suffered latPr rm in May 2013".* In the final sentence in paragraph 33 he says this, *"it was clear that he needed urgent psychiatric care as his condition was causing serious concern to his family".*

83. Dr Friedman at paragraph 62 of his report dated July 2020 **[243 TB]** said this, *"It seems that there was initially some concern about his behaviour and content of his speech. He was subsequently seen in October 2012 by psychiatric services. In my opinion, he received an extremely detailed and competent assessment at that time. It was recognised that there had been some possible changes caused by the head injury but there was no evidence that he was seriously mentally unwell or that he was suffering from signs of a psychotic illness. I believe the outcome of this assessment was reasonable and good practice was followed by discussion with a consultant psychiatrist who reasonably suggested that he requiredfurther neuropsychologicalfollow-up".*

84. He continued at paragraph 63, *"I note that there was a referral to the neurosurgeons who replied reasonably that there was no evidence of any need for him to be seen in clinic*

because there was no acute problem that could be addressed by neurosurgeons" and at paragraph 64, *"He was subsequently seen in the post traumatic clinic in 2013. I would comment that at this time there is no evidence that he was seriously psychiatrically unwell. His family did not attend with him and he would appear to have been functioning at a reasonable and independent level. It seems that he had been working as a porter and was travelling and seeing friends. There was some concern that he may have been more irritable and had some mild cognitive impairment and an appropriate referral was made in relation to that".*

85. He concluded at paragraph 66 that, *"In my opinion, I cannot find any evidence that the assessments by psychiatric sen1ices in this matter were negligent. I do not think that there was evidence from any of the assessments that 1 have seen that would have suggested he was siif.fering from an organic psychosis due to a brairi injury. It would seem that he was behaving reasonably for much of the time. It would seem that there was some evidence of mild cognitive change or personality alteration that might have been attributed to the head injury, but I do not believe that the assessments and interventions that were carried out by psychiatric services were unreasonable. 1 note in particular that he was followed up a few weeks after his initial psychiatric assessment to see if he was settling or having further problems and I believe that this was good practice".*

86. In the joint statement dated 22nd October 2020 **[319 TB]** the two experts agreed that there were no prodromal psychotic features when Thomas was reassessed on his return from China at the Single Point of Access on 16th October 2012.

87. Dr Friedman noted, *"his continuing preoccupation about his sexuality but there was no evidence that he was obviously psychotic. In retrospect, his concerns can be seen as prodromal for his subsequent serious episode of mental illness later in 2013 but did not consider that there was sufficient evidence from the assessment that he was clearly psychotic prior to that date".*

88. Dr Mahapatra noted, *"that the claimant's complaints on 16'" October 2012 were totally different to his previous symptoms: he complained of forgetfulness, change of personality, repetitive behaviour, inability to recall anything related to the road traffic accident in Beijing, wanting to question God about people's ignorance on certain subjects and people seeing him as a stereotype. He was also ruminating about sexual matters and*

meaning of life, his appetite was described to be excessive. His family had reported him to have an easily rousable temper".

89. I have considered the available evidence and reflected at length on the recollections of Thomas's family. What is apparent from the expert evidence is that the symptoms that Thomas might have been suffering from between the accident in China and the breakdown in May 2013 can be divided between those which are consistent with the effects of a frontal lobe mJury and those which can now be seen retrospectively as identified by Dr Friedman.

90. I am satisfied that during the relevant period Thomas was exhibiting symptoms of anger and that he was showing more anger to those closest to him that he had done previously. I am equally satisfied that he was exhibiting symptoms of frustration , of disinhibition and had mood swings. He had a loss of memory and his concentration was reduced. He had dietary issues and chose unusual food preferences, was exhibiting elements of obsessive behaviour and had become philosophical. Further I am satisfied that he was repetitive in certain behaviours and that he spent a lot of time on his computer. He showed, initially at least, no concept of pain.

91. Dr Mahapatra and Dr Friedman accept in the second joint statement **(318 TB]** that there is evidence from the medical records that Thomas had at least prodromal psychiatric symptoms prior to going to China. They set out in the answer to question l(a) a number of extracts from the medical records to support that. It is not necessary to repeat them verbatim here.

92. Dr Mahapatra considered that, *"there had been no psychotic symptoms present nor was he ever diagnosed to be suffering from a psychotic illness during his treatment by the Psychiatric Services during the years 2009 to 2011. He had remained well without requiring any psychiatric help or treatment between October 2009 to December 2010 when he had recurrence of depression, anxie ty, suicidal thoughts, of struggling to concentrate and part of his brain not in reality with his thoughts going round and round and hearing his voice talking to him. It was considered that he had some psychotic elements to his thinking when it was decided to treat him with olanzapine 5mg at night. He appeared to have continued to take this medication. He went back to his Hull*

University Course and had obtained a 2:2 Honours Degree in International Law in June 2011".

93. Dr Friedman on reviewing those entries considered that *"they describe major concern about the development of prodromal or early symptoms of psychosis. Dr Friedman considers that a number of clinicians raise concerns that the claimant was showing early symptoms of psychosis and that due to these concerns it was decided to start the claimant on olanzapine, an antipsychotic drug. Dr Friedman considers that anti-psychotic drugs would not have been prescribed for a depressive disorder and were indicated due to concern that he was developing a psychotic illness. Dr Friedman considers that his symptoms at that time included beliefs that, in retrospect, were probably the start of his delusional beliefs together with concerns about auditory hallucinations. Dr Friedman considers that whilst the claimant was not under constant psychiatric review during these years that is not a sign that he was psychiatrically well. Dr Friedman considers that his presentation with fluctuating symptoms of early psychotic symptoms typical of the early stages of a psychotic illness such as bipolar disorder. Dr Friedman considers, as is typical in many cases of psychotic illness, that the claimant did not have full insight into his illness and this caused him not to remain compliant with his medication".*

94. I am satisfied that Thomas's reported paranoia and fixed conversation, his bizarre thoughts and ruminations about religion were symptoms that can be seen as prodromal. I am equally satisfied, on the balance of probabilities, that he was not exhibiting obvious psychotic symptoms during the relevant period to which this issue relates.

95. The assessment at the Single Point of Access was thorough. It was based on discussions not only with Thomas but importantly with his father. There were *"no reported strange, odd thoughts"* (see paragraph 61 above). I am not satisfied on balance of probabilities, that known symptoms of psychosis, hallucination and delusion, have been identified as existing during this relevant period.

96. We know that when in Italy in April 2013 Thomas displayed bizarre behaviour. Mrs Vinegrad sets out in her statement **[108 TB]** at paragraph 37 that *"he had become to act in a sexually inappropriate manner towards the man and his wife. For example removing his top at the brealifast table and telling people that the man's wife was 'coming on to him"'.* Mr Vinegrad recalls at paragraph 48 of his statement **[96 TB]** that *"we were*

contacted by Thomas 's employers, who were very concerned about his mental health. They stated that they had to send Thomas home because he had behaved inappropriately. I was informed that Thomas believed that the father of the children had said that Thomas could have a sexual relationship with his wife, and believed that the six year old son was gay".

97. When the documents are considered it is apparent that we do not know a great deal of the detail of what actually did happen when Thomas was in Italy. Importantly there were no specific indicators in the lead up to the trip that Thomas was on the verge of any breakdown. Miss Vinegrad although unhappy that Thomas was going to Italy confirmed , as set out earlier, that there was not a big build up beforehand.

98. Mr Vinegard was asked in cross examination if he agreed that the deterioration came when Thomas went to Italy. He said *"in principle yes but there are events that led up to that. It was a disaster waiting to happen. When he was with me he was calm. His physical well-being was the main concern. More concerned about his physical presentation. At the time we had the meeting all was good. When he went to Italy all the other problems came out. From Italy onwards it was not physical it was mental".*

99. He was further asked about what had happened in Italy. He said that he thought that he heard about it because he had got an email, and that they got infonnation *"bit by bit".* He was asked whether or not he was shocked and replied, *"not so much shocked just surprised".* He said that it seemed *" far fetched"* and to think that *"that could happen is unusual".* From that I draw the conclusion that Mr Vinegrad was not concerned about any deterioration in Thomas's mental health at the relevant time and before he went to Italy. He was more concerned about his son's physical well-being. There were no obvious indicators being exhibited by Thomas sufficient to alert Mr Vinegrad as to what might be about to happen.

100. Balancing all of that I am not satisfied that that there was any significant deterioration in Thomas's symptoms and presentation until he went to Italy. It is the position that despite his family not wanting him to go they recognised that they could not stop him because he was a grown man. Indeed, it is the position that he was able to organise the trip himself and arrange his own employment. He was able to make his own way to Italy and to the family with whom he was to live and work.

101. Mr Vinegrad accepted when cross examined that he had probably paid for Thomas's air fare to Italy. Had he had any concerns that Thomas was exhibiting any psychotic features then I am satisfied that he would have recognised those and acted appropriately to try to prevent the trip. That he did not do so is supportive of the finding that no such symptoms were manifesting themselves. As he said to Dr Friedman that at the time, the trip to Italy *"did not seem ridiculous"*.

102. I have already refen-ed to extracts from the assessment by Nurse Rusling. Consideration of the medical notes and records do not mention or identify any psychotic features for the relevant period. At the follow up appointment with Nurse Illidge on the 29th October 2012 **[192 MR]** it is recorded that *"there were no signs of acute mental health"* and again at the meeting with Dr Humphreys on the 22nd March 2013 **[209 MR]** there was no mention of any psychotic features being exhibited by Thomas.

103. I have already dealt elsewhere in this judgment with the inconsistencies relating to Thomas sending the prayer mats at Christmas. I am completely satisfied that he did not send those at Christmas 2012.

104. When I stand back and consider all of the available evidence I have reached the conclusion on balance of probabilities that the behaviours identified were not indicative of symptoms of psychosis, they were consistent with somebody who had suffered frontal lobe injury.

Absent any proved or admitted breach of duty by the Second and Third Defendants would there have been the recommendation of antipsychotic medication?

105. It is accepted that absent the Second Defendants' admitted breach of duty by them failing to see Thomas in a post-traumatic concussion clinic when he returned to Hull from London, that there would have been a neuropsychological assessment of him by approximately Christmas 2012. Professor Al-Din and Dr Mumford, the neurologists, in their joint statement **[304 TB]** said, *"our opinion is that an assessment by, and admission to, the local neurorehabilitation team (i.e. a post-traumatic syndrome ('concussion) service) would ideally have happened within 4-6 weeks. We recognise that these services are stretched in terms of their capacity in many parts of the UK and accept that such a short time frame may not have been feasible in this specific case"*.

106. They also concede, following cross examination, that Thomas would have been seen in a further neuro-rehabilitation clinic following the neuropsychological assessment referred to above. They suggest that that would have occurred around Christmas 2012 or shortly thereafter.

107. The importance of that is that the case is put on the basis that Thomas would have seen a psychiatrist in 2012. Therefore, any psychiatric referral would have had to have been made, on balance of probabilities, at the hypothetical neuropsychological assessment, or at the second neurorehabilitation clinic.

108. The neurorehabilitation experts are Dr Harris and Dr Landham. Both experts gave clear evidence. I have read again their respective reports and the joint statement.

109. If there had been the second neurorehabilitation clinic referral both experts agreed that that would have been in the format of a multi-disciplinary assessment. They said at paragraph 7(a) of the joint statement **[339 TB]** *"multidisciplinary assessment, including a neuropsychologist, within days or weeks. If he was still in PTA this would have been documented and such an assessment should have been delayed. If he had emerged from PTA, then treatment could have started".*

110. They did not however believe that Thomas would have been referred to acute psychiatric services. At paragraph 9(a) **[340 TB]** in answer to the question would there have been a referral to acute psychiatric services they responded, *"we recognise he had cardinal signs and symptoms of frontal lobe injury - not consistent with any acute non-traumatic mental health illness - so he did not require a psychiatric referral, and he was also already known to the mental health team".*

111. Dr Harris accepted when giving his oral evidence that in October 2012 there was no psychiatric referral because of the absence of psychiatric factors and that the pattern of symptoms as described by Mrs Vinegrad needed to be correct ifthere was to be a referral, *"I believe so".*

112. As I have indicated elsewhere in this judgement I did not find Mrs Vinegrad a good historian. It follows from that that it was unlikely, on Dr Harris's analysis, that there

would have been a psychiatric referral made at the second hypothetical neurorehabilitation clinic.

113. Mr Rimmer was careful to revisit this issue in re-examination. Dr Harris said that he would have expected any neuropsychologist to have carried out a full assessment and he referred to the three stages of that assessment. However, on balance of probabilities he could not say whether or not a psychiatrist would then have become involved. Dr Harris did say that he believed that a psychiatrist would be brought in, in about early 2013, due to Thomas's *"obsessive thinking, his mania, impulsivity and pushing the boundaries"*. He said that that would be *"at the latest by the early part of January 2013"*.

114. I have thought about that answer. I am not persuaded that that would have been the position. Mr Fraser suggests that the expert was led to that answer by the nature of the re-examination. I accept that the re-examination was very skilful. The expert was reminded of the passages of evidence from both Mrs Anita Vinegrad and Miss Kim Vinegrad's evidence. I remind myself that for me large aspects of Mrs Vinegrad's evidence were unreliable and that Dr Harris had said that the pattern of symptoms she described would have needed to be correct for a psychiatric referral to have been made.

115. I balance Dr Harris's opinion with the evidence of Dr Landham. He accepted that following the first hypothetical neuropsychological assessment that there would have been the follow up neurorehabilitation appointment. He did not disagree that that might have been around January 2013 but did make the point that it would have been entirely dependent on available resources.

116. He was asked in cross-examination as to when the involvement of a psychiatrist might occur. He suggested that if the symptoms were worrying then his approach would be to get the neuropsychiatrist to intervene. If the symptoms were not severe then he would not do so, it depended very much on the symptomatology. He was asked by Mr Rimmer how he assessed the level of risk and subsequent destination for referral.

117. His evidence was that there might be a referral if there were open and obvious symptoms. Hallucinations were an indicator but delusions he did not see as being that serious as most frontal lobe injury patients have delusions. Mr Rimmer referred him to the fact of a patient who had had a previous history with their mental health and asked if

that in itself was what he described as a *" greater red flag"* . Dr Landham said that that was not necessarily an enhanced indicator. In his view it depended on how severe the symptoms were at that moment in time.

118. The existence of previous symptoms was further explored, if there was the existence of some previous history and symptoms whether or not that would raise his concern. He was very measured in his answer and said that he would be more concerned but that did not mean that it was necessary to take any action. Added to which in this case Thomas had stopped taking his medication months ago.

119. On balance Dr Landham was of the opinion that a referral to a psychiatrist was not likely at the second hypothetical appointment.

120. Dr Friedman in his report at paragraph 61 **[243 TB]** said *"Mr Vinegrad returned to the United Kingdom following his head injury. I have reviewed the expert neurological opinion in this matter and agree that he was not showing any acute signs of brain disorder and that his difficulties were related to brain trauma affecting his cognitive or other abilities. It would therefore seem reasonable for him to be followed up in a neurorehabilitaticn clinic (this subsequently occurred but I consider that this is a separate issue from the development of his psychotic illness). I would defer to the expert opinion of others as to the necessity of an MRI scan at that point but I do not consider it was necessary for a psychiatric assessment".*

121. I remind myself at this stage that I have already found that Thomas was not at the relevant time exhibiting symptoms sufficient to alann or alert the physicians as to any psychosis. When I balance the evidence, I have reached the conclusion that at the hypothetical appointment, whether that would have been at the end of 2012 or at the beginning of 2013, that there would not have been a referral to psychiatric services.

122. That conclusion is assisted by the fact that we know that there was an assessment carried out on 16th October 2012 (Nurse Rusling) and a review on 29th October (Nurse Ilidge). There was also the appointment at the neuro rehabilitation clinic on 22nd March 2013 (Dr Humphreys). It is a fact that at those appointments none of the clinicians considered that a psychiatric referral was required. Mr Fraser makes the point in his.

closing submissions that the Claimant no longer pursues a case that at any of those appointments was the decision taken at that time the wrong decision.

123. Irrespective of the conclusion reached above I have considered whether or not if there had actually been a referral to a psychiatrist at the hypothetical appointment would that psychiatrist have prescribed Olanzapine?

124. To help put matters into context it is of course the position that Thomas had been prescribed Olanzapine prior to 2012 and had taken that medication, albeit on occasions it seems intermittently.

125. The prescription or not of Olanzapine was of course within the remit of the expe1i consultant psychiatrists and whether they felt that such a prescription was appropriate.

126. Dr Mahapatra confirmed the opinion set out in the joint statement prepared with Dr Friedman that there were no prodromal or psychotic features when Thomas was reassessed at the Single Point of Access on 16 th October 2012 and that there was no overwhelming case for recommencing Olanzapine in September 2012.

127. In the same joint statement Dr Mahapatra was of the opinion that *"Treating him with Olanzapine or any other antipsychotic drug with or without an anticonvulsant drug would have been appropriate and would have been likely to manage the behavioural problems and would have been likely to prevent the major breakdown in May 2013"*.

128. On my analysis Dr Mahapatra was not persuasive that it would have been likely that Olanzapine would have been prescribed. He was asked about the serious side effects of the drug. He said *"all have serious side effects. He was able to tolerate it before, might not be a bad idea"*. That for me was some way from saying that Olanzapine would have been prescribed.

129. Dr Mahapatra was taken to the assessment carried out by Nurse Rusling **[187 MR].** in that assessment is a reference to Olanzapine as follows *"has previously been on Olanzapine prescribed by Dr Ali at the request of Julie Moore in January 2011 - stopped when went to China no problems reported having stopped the medication"*. In the previous section relating to the past medical history the records state, *"see reports no physical health problems reported does not require medication"*. Dr Mahapatra accepted

that it was not possible to discern from the entry refe1Ted to above if Thomas did actually discuss Olanzapine with Nurse Rusling. The entry could be interpreted either way. Dr Mahapatra accepted that there was no recommendation for Thomas to be prescribed Olanzapine in that record.

130. Mr Vinegrad was also taken by Mr Fraser to the assessment by Nurse Rusling. He was asked when he saw the nurse if there was any discussion about Olanzapine and he replied *"no".*

131. I have read the entry on a number of occasions. The assessment by Nurse Rusling is detailed and has plenty of content. On baiance of probabilities had Olanzapine been discussed with Thomas by Nurse Rusling I am satisfied that any such discussion would have been recorded in that assessment.

132. It was put to Dr Mahapatra that the Defendants accept that it is possible if there had been further psychiatric intervention , that Olanzapine might have been discussed but that given the absence of overt psychotic features that was a possibility and not a probability. Dr Mahapatra responded by saying that *"obviously it wasn't and it was not recommended".* He was then asked if he agreed that he couid not say on the balance of probabilities that there were discussions regarding Olanzapine. His response was *"any opinion I give would be conjecture"* which I take as confirmation that he could not say on the balance of probabilities that there would have been discussions with Thomas about the prescription of Olanzapine.

133. Mr Rimmer asked Dr Friedman if he felt that at the hypothetical appointment the subject of Olanzapine would have been raised. Dr Friedman explained that in his view firstly Thomas would have had to have turned up for the assessment (he explained that many patients do not). He accepted that there could have been discussion about the history and medication but that in his opinion the focus would have been on the brain injury and the frontal lobe injury.

134. He continued that if Thomas had been seen by a neuropsychiatrist in Spring 2013 then there could have been a discussion about Olanzapine. On further questioning he said that in his opinion there were no psychotic symptoms in May 2013. There was no evidence of

Thomas being floridly psychotic at that stage. He accepted that there could have been some reference to Olanzapine *"somebody could have mentioned it"*.

135. Dr Friedman went on to explain how he was still worried about prescribing such medication and that he would first want to use other means of treatment. It was put to him by Mr Rimmer that an important element of treatment is to prevent overt symptoms. He accepted that but said *"that there was no evidence he was going to become floridly psychotic, there was not the evidence for that"*. He went on *"had he turned up with his father and had said Olanzapine helped me and asked for it then that might have helped with a compliant family"*. He was refeITing of course to being helped in making the decision as to whether or not Olanzapine would have been prescribed.

136. I have balanced the respective arguments and considered the available evidence. I give huge credit to Mr Rimmer for the skilful way in which he deals with Dr Mahapatra's evidence in his closing submissions. However, for me and for the reasons explained earlier he was not a persuasive witness. Dr Friedman's opinion was far more compelling. I am satisfied that there were no identifiable markers that Thomas or his family thought that the prescription of Olanzapine was appropriate or indeed necessary.

137. Therefore, in conclusion and on the balance of probabilities I am satisfied that had there been a psychiatric referral then there was a possibility that Olanzapine might have been mentioned but I am far from persuaded that it would have been recommended or prescribed.

Would Thomas have taken Olanzapine upon recommendation of the same?

138. The starting point is the previous history. In the medical notes and records is a letter dated 13th January 2011 **[38&39 MR]** to Dr Partridge Thomas's General Practitioner from Julie Moore a senior nurse in the Community Mental Health team who were helping Thomas when he had his original problems with his mental health. In that letter the following is recorded, *"we agreed that St John's Wort is not as effective as it needs to be at present and I discussed with him about having some different medication either an antidepressant or an antipsychotic. I explained that I needed to discuss the situation with Dr Ali and I would contact him and yourself regarding any medication change. I do feel that things are quite tenuous at the moment and it feels if things could change once again*

especially as he gets near to his exams and pressure begins to build regarding this, as well as the internal pressure about his self-esteem and lack of relationships". The letter continues *"I have discussed the situation on 20th January 2011 with Dr Ali and he felt a small dose of antipsychotic medication may be helpful. He also felt that antidepressants can cause the psychotic symptoms to become worse so felt Thomas should stop taking the St John's Wort. Therefore please can you prescribe Olanzapine 5mg once a day at night. Dr Ali is due to see Thomas at the beginning of February 2011 so will review his mental health and medications then. I have also spoken to Thomas today on the phone and he is agreeable in taking the medication. I have discussed the reasons for and potential side effects"*.

139. The medical records show that there were repeat prescriptions of Olanzapine from the 2nd February 2011 to the 8th June 2011. The notes also show that Thomas did not attend a follow-up appointment with the mental health team on 23rd February 2011. On 9th June 2011 there is a record of a discussion between Thomas and Dawn Slack a senior care officer in the Community Mental Health team which says as follows, *"telephone call from Tom to inform me that he has got a job in.....Scotland .....! discussed medication with Tom and irifonned him that he should register with a new GP as soon as possible and make an appointment to see a GP to arrange for a repeat prescription. Tom told me that he had planned for his father to get repeat prescriptions from his current GP and send them to him. I explained that I would be writing to his GP informing her of his discharge and that he would be advised to register with a new GP. There was no evidence of any risk during my call and Tom was optimistic about the future. I suggested that his medication could be managed through his GP and that should he feel that he is relapsing the GP could refer him to the appropriate team (in Scotland)"*.

140. Thomas was subsequently discharged from the mental health service and a letter confirming that was sent to his General Practitioner on 14th June 2011 which confirmed that *"Tom was advised to continue to take his medication as prescribed and to register with a new GP in order to obtain further prescriptions and discuss future mental health needs"*.

141. The notes and records show that the repeat prescriptions continued and on 3rd October 2011 **[70 MR]** there is an entry *"req for meds travelling for 3m"*. On 2nd March 2012

there is a further entry which states *"moving to Scotland according las review by mental health team. Explains missed appointments and apparent non-compliance with meds".*

142. There was some confusion during the trial as to whether or not there had actually been a continued prescription of Olanzapine and if so from which GP surgery. Mr Vinegrad gave very clear evidence that he had actually collected prescriptions and had sent them to Thomas he believed both in Scotland and in China. I am perfectly satisfied that that was what did happen and that if there is an anomaly Mr Vinegrad's evidence was persuasive. I am satisfied that he did send some prescriptions to his son. What of course we do not know with any certainty is whether Thomas took the medication that was prescribed.

143. Pausing there, I should at this stage deal with the criticism from the Defendants about the failure of Thomas to provide any evidence at the trial or generally. They invite me to draw an adverse inference from that failure. They argue that Thomas would have been well placed to give evidence about what his reaction would have been to the suggestion of recommencing Olanzapine in December 2012 or January 2013 because he could have said how he had tolerated it previously and why, and when in the past, he had stopped taking it. In his closing submissions Mr Fraser made the point that there is no explanation for Thomas's absence from the trial and that there is no suggestion that he was not fit to give evidence or that if he had done so that might have threatened his mental well-being. I was referred to the decision of ***Wiszniewski.***

144. In that case four principles establish and guide when the Court may be entitled to draw an adverse inference from the absence or silence of a witness who might have been expected to have given evidence on a particular issue. The fourth of those principles is that if the reason for the witnesses' absence or silence satisfies the Court then no such adverse inference can be drawn.

145. Mr Rimmer deals with this issue fully in his closing submissions. I do not need to repeat what is set out there suffice it to say that I agree with him that in respect of Thomas such an inference is neither justified or appropriate. In very basic terms, he has brain damage, his cognition is impaired, he suffers with a psychiatric illness and he does not have capacity to conduct this litigation. The extent of his understanding of the importance or relevance of any evidence that he might have given would I am satisfied have been open to question and it follows that the reasons for Thomas's absence for me were

justified. It follows that I am not prepared to draw an adverse inference from Thomas not giving evidence.

146. I accept that in the hypothetical situation Thomas and his family would have known more about Thomas's actual condition and that given that knowledge they would have been better placed to have helped Thomas take the medication had the same been recommended. However, I do have some concern how that might have actually played out, how it might have been perceived by Thomas, how he would have reacted to any offers of help no matter how well intent ioned, and how much support he would in reality have had. As mentioned earlier in this judgment there exist indicators, in various aspects of the notes and records , of apparent tension within the family. Thomas was said to have felt better and more relaxed when he was not with them.

147. I am not satisfied that having that knowledge in the hypothetical situation takes me to the conclusion that Thomas would actually have taken the medication had it been prescribed.

148. Thomas did not believe that anything was wrong with him. That much was made clear in the statement of Mr Vinegrad when he said, *"Thomas largely does not believe that there is anything wrong with him and denies having any suicidal thoughts"*. Mr Vinegrad described in his oral evidence that towards the end of Thomas's stay in China that he had started to become unwell again. He described how Thomas had changed his job and had had his passport and other personal effects stolen. All of that added to the stress, his father said, *"I do not know if he was stopping his medication but know he became poorly again"*. For me that was a direct indication , as far as Mr Vinegrad was concerned, that it was a possibility that Thomas had stopped taking his medication which might have well led to him feeling unwell again.

149. Mr Vinegrad was asked whether or not in 2013 anybody was contacted about Olanzapine and he replied *"I can't recall what he was taking then. I know that he was taking something but cannot recall what it was"*.

150. Following his admission to St Andrews Place Thomas was on Olanzapine. There is a note dated 18th July 2013 as follows *"Tom has gone on leave - not in the unit, he has asked if his olanzapine could be reduced to 5mg - due to lethargy"*. He did however in an

assessment dated 19th July 2013 agree that Olanzapine had had a positive effect on his condition **[1237 MR]** and agreed to remain on the drug.

151. Mr Ri1mner suggests that with monitoring, support and understanding of his condition Thomas would most likely have taken his medication. He also suggests that Thomas shows insight into his own condition for example when he was in Turkey in 2015 he referred himself to a mental health unit **[977 MR].** Whilst I understand the thrust of the argument, the note made by his General Practitioner following that referral and dated 7th January 2016 says this, *"patient says he feels tired and thinks this is due to his current medication. It seemed like he is not compliant with his medication because he did not answer my question when I asked him if he was taking his medications regularly"*. The note suggests that there were real concerns that Thomas was not compliant with his medication, referring himself to the mental health unit is encouraging but not enough to allow me to conclude that he was being compliant with his medication and had good insight.

152. In a letter to the General Practitioner dated 14th July 2016 **[978 MR]** Dr Iyer a locum Consultant Psychiatrist said this, *"there appears to be some ambivalence about his prescribed treatments. He accepts that whilst he has been on oral medication his adherence has not been I00%. At interview he accepted our rationale and has agreed to take a smaller dose of medication in the long term. He did ask me if this was for an indefinite period and I indicated that as he has had significant episodes of hypomania it would be useful for him to continue with prescribed treatments, at least for a couple of years, he agreed with this"*. This provides another indicator that Thomas was not compliant with his medication.

153. Dr Friedman set out his opinion on this issue in his letter dated October 2020. He said this is at paragraph four, *"There is obviously an issue as to whether or not the claimant would have agreed to have taken this medication, in my opinion, it is unlikely on the balance of probabilities that he would have taken the medication. In clinical practice, a significant number of patients who do not have insight into their illness, as in this case, are generally non-compliant with medication because they do not consider that they are unwell or need treatment. This is particularly the case early in their illness course before they have become floridly unwell"*.

154. I have considered all of the above. This has been a difficult and fine balancing exercise. I accept that there are medical records that show that on the face of it Thomas was receptive to continuing to take Olanzapine. However, there are also records that indicate the reverse and that he might not have been compliant. I have already refe1Ted to my concerns as to what might have happened "on the ground" and within the family unit and Thomas's reaction to that. On balance I have concluded that there remains a significant concern for me that Thomas would not have taken his medication had it been presclibed or, that if he had actually done so, then he would not have done so consistently duling the relevant period so as to avoid the consequences of what occuITed in May 2013.

Would the use of antipsychotic medication, or any other medication, have avoided the Claimant's psychotic episode and/or breakdown on 8th May 2013 and subsequent hospitalisation?

155. Dr Mahapatra was of the opinion that Olanzapine was likely to control the behavioural an<l personality change and was likely to prevent the major breakdown in May 2013 if Thomas had been regularly monitored **[321,2(c) TB].**

156. When giving his oral evidence he said thal *" Olanzapine might have helped him"*. He went on to explain that he was not somebody who was a great user of the drug (in the sense of presc1ibing it) but said that as Thomas had taken it before and *"was able to tolerate it that it might not be a bad idea"* (to presclibe it). He confinned that if Olanzapine was prescribed then the patient would have had to be fully compliant for it to have taken effect.

157. Dr Fliedman in the joint statement **[321,3(c) TB]** said that Thomas had prodromal or early symptoms of psychosis plior to going to China *"which were controlled by olanzapine"*. He concluded that *"on the balance of probabilities this pattern of his psychotic illness would have occurred, in the absence of the traumatic brain injury, with relapse following the cessation of taking his olanzapine"*.

158. The logical conclusion from that is that if stopping taking the medication caused a relapse then taking the medication would have helped control the symptoms at the outset. As previously mentioned Dr Fliedman said that if at all possible he would try not to medicate a patient but would look to use all other available means before doing so. He

accepted when it was put to him by Mr Rimmer in cross examination that when Thomas became floridly psychotic that the prescription of Olanzapine did seem to bring his symptoms under control. He accepted that the likelihood was that if he had taken Olanzapine it would have had an effect, either ameliorated or prevented the symptoms. He said *"it might have done nothing. If he had taken it regularly it probably would have done something"*.

159. In his letter of October 2020 Dr Friedman says this at paragraph four, *"I have been asked whether the prescription of Olanzapine in 2012 or 2013 would have prevented the Claimant becoming unwell. This is not a simple matter. It is possible that if the Claimant had been prescribed Olanzapine at that time and taken it regularly then this might have prevented him becoming unwell in May 2013"*.

160. He continued at paragraph five *"If the Claimant had been persuaded or agreed to take medication then this may have prevented him becoming unwell or ameliorated his initial presentation in May 2013. There would also have been a significant risk that he would have continued to have become unwell in May 2013 even while taking medication. There is no guarantee that the Olanzapine would have prevented him from becoming unwell in May 2013. I note that the subsequent entries in the medical records and the more recent medical records show that the Claimant has become unwell despite taking Olanzapine. In my opinion, this provides good evidence that the Claimant does not have the type of bipolar disorder that responds well to medication. There are some patients with bipolar disorder who are very respondent to medication and remain relatively well whilst there are other patients, such as the Claimant, who are more treatment resistant and remain unwell, with frequent relapses, despite taking medication"*.

161. At paragraph six he concluded *"In my opinion, even if the Claimant had taken medication which prevented or ameliorated the episode of illness in May 2013 he would have inevitably gone on to develop his bipolar disorder at some point over the subsequent months in an entirely similar manner to that which occurrecf'*.

162. Under cross examination he maintained that opinion but accepted that the taking of the drug *"probably would have done something"*. He was asked about the range of possible outcomes. His view was that at the highest it would perhaps have prevented a breakdown

for a few months (although he still maintained that there would have been a breakdown) and that at the lowest it might have ameliorated the symptoms.

163. Balancing all of the above I am satisfied that it is likely that Olanzapine would have had some beneficial effect had it been prescribed. I am not satisfied however on the balance of probabilities that such a prescription would have meant that Thomas would have avoided having a breakdown aitogether. Given that I have already found that on balance Olanzapine would not have been recommended/prescribed in the hypothetical situation and that even if it had been prescribed it is unlikely that Thomas would have taken it consistently, or at all, I need not go further and speculate as to how long Olanzapine might have had a benefit for.

Conclusion

164. Given the findings made in relation to the key disputed issues it follows that the claim must be dismissed.

165. I appreciate that I have not heard any submissions in respect of costs. I understand that **tliis is a QOCS case and therefore do not anticipate any' difficulty vvith the v1ording of *an*** final order. However, if I am wrong about that then I am sure that the respective legal teams will tell me and I will then convene a separate hearing to deal with any outstanding issues.

166. Finally, I must say a few words about the Vinegrad family. I understand that my <lecision will he a disappointing one for them. This has been a difficult and upsetting case. Having been involved with it, read the papers and considered the problems that have been encountered I have little doubt that they have all been through a great deal and endured some exceptionally difficult and unimaginably woITying and upsetting times. I have nothing other than enormous respect and admiration for them and for how they have coped with those pressures.

His Honour Judge Cooper
22nd January 2021