Professor John Scott Werry CNZM

Child & Adolescent Psychiatrist

NZMC Registration No 4344

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11/07/09

[redacted] **Confidential and Legally Privileged**

Legal Advisor

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Re: Fareham House - Your ref SOC329/654 Psychiatric Report

My name is John Scott Werry and I am emeritus professor of psychiatry in the University of Auckland and registered medical specialist in child and adolescent psychiatry. I have practised child and adolescent psychiatry since 1960. I have researched and have a special interest and have published in brain behaviour relationships and in pediatric psychopharmacology. I was foundation head and professor of psychiatry at the Auckland Medical School (1970-1991) and worked during that period at what is now the Starship Children's Health in Auckland.

I have read the materials you sent me and in answer to your questions I opine as follows:

1. Was temporal lobe epilepsy a legitimate diagnosis in the 1960's I expect you mean legitimate when there were no actual seizures as there has never been any doubt but that there is an entity of Temporal lobe epilepsy in which the manifestations were seizures or where there were clear epileptiform focal disturbances in the temporal lobe. The controversy relates to "behavioural" rather than true fits as a legitimate diagnosis in the 1960's. The summary paper by the Principal entitled "Temporal Lobe Epilepsy – Related to Difficult Behaviour" shows that medical thinking held that the manifestations of TLE could be entirely "behavioural" and or "physical symptoms" rather than classical fits. I can also aver that in the 1960's there was considerable discussion about what became known as epileptic equivalents that is[redacted] type of behaviours that were not clearly fits. One of the most commonly argued behaviours was emotional instability particularly angry or aggressive outbursts. It followed that if you accepted the view of epileptic equivalents then the logical next step was to give anticonvulsants.

This view generated considerable debate though and tended to polarise doctors for or against. My own view in the 1960's was that the case was "not proven" and I did not use it in my clinical work but plenty of other psychiatrists and doctors did. Further, there were frequent and some highly publicised reports endorsing anticonvulsants on a wider scale (e.g. [redacted] I think a successful businessman who felt his life had been changed when he went on an anticonvulsant and he even set up a foundation to promulgate the much wider use of one such drug – phenytoin or Dilantin).

The principal went to considerable lengths to document the range and numbers of symptoms that suggested TLE in a number of the girls showing a degree of care and responsibility. However, the extent to which sufficient symptoms were present in all the girls who got the diagnosis and treatment is not stated but I think the diagnosis was being made in many solely by EEG (plus of course the difficult behaviour which they all had to varying degrees or they would not have been in Fareham House but in foster care.)

In the case that you sent me of [redacted] the behaviours that were described would in the 1960's have incurred with some doctors the possibility of a diagnosis of TLE. The particular behaviours are extreme emotional instability with hizzy fits and aggression. Today we would diagnose her as having a conduct disorder with borderline personality features. However, it is of interest that there is a group of American academic child psychiatrists who would diagnose this as bipolar (manic depressive) disorder. The importance of this is that it shows that the 1960's idea that this kind of behaviour lay in some kind of brain disorder persists today.

However it is clear from the notes that what happened at Fareham House was somewhat different. [redacted] was admitted to [redacted] when her behaviour became too disturbed and she may have been the first to be given the diagnosis. The local doctor Dr [redacted] must have read or heard about TLE causing disturbed behaviour and he contacted Dr [redacted] at [redacted] Hospital. Dr [redacted] then predicted that most of the girls would have TLE and organized to test them all. All but one were found to have grossly abnormal EEG's. Thus what happened here is one case which was sent to [redacted] may have been instrumental or at least part of a process in which the diagnosis came to rest primarily on EEG's done in [redacted].

By 1970 or so, it was felt that Dr [redacted] was misinterpreting EEG's and seeing TLE and that the diagnosis of TLE was in fact being overdiagnosed by [redacted] doctors.

2. Was an EEG an appropriate way to diagnose TLE? The answer to this is yes and no. If one were to observe the clear epileptiform focus arising in the temporal lobe a tentative diagnosis could be given. I think though there is little doubt that Dr [redacted] and [redacted] who did and read the EEG's went beyond this very narrow and specific type of EEG pattern and made diagnoses that others would have not. In any case the sheer numbers of diagnoses made on an EEG basis are well beyond expectations on the basis of the true frequency of the disorder.

3. How appropriate was the diagnosis among residents of Fareham? Given that you can diagnose TLE from an EEG the issue is not the use of such but the reliability of interpretation of the EEG. There was at that time some debate as to exactly what

constituted an abnormality and what it meant especially the kind of abnormalities seen in those with psychiatric or behaviour disorders. However, I think it fair to say that what most neurologists would have said was a typical TLE focal abnormality would not have been what Dr [redacted] and [redacted] were calling TLE. Thus I think it is pretty clear that what they said was TLE was not and they were overinterpeting the EEG data. However, remember that to get into Fareham House required the girl to have substantial behaviour problems (of the so called epileptic equivalent type) unsuited to foster care. Thus there was a presumption of not just EEG but also significant behaviour to support the diagnosis. Of course, medical opinion was quite divided as to the validity of epileptic equivalents and though I was a dissenter in the 1960's there were plenty of others who would embrace such a concept. It would however be fair to say that by about 1972, medical opinion in Wellington was that Dr [redacted] and [redacted] were over diagnosing TLE and that their practice would by then be considered amodal. That however was probably not the case in the 1960's. I was out of NZ at that time and all I can say is that their view could not at that time be considered other than one held by a substantial minority of medical opinion. What needed to be done to establish malpractice and wasn't was for a neurologist to read the EEGs and having found error to have pointed it out to [redacted] and [redacted] and discussed it with them and then there might have been an expectation of change of practice. For this to occur there would have had to have been enough peer concern to take the matter up with medical authority in Wellington or NZ. The fact that it was not I think says something.

4. Was Nydrane an appropriate treatment for TLE? Yes at that time

5. Is there anything to suggest that Nydrane was being prescribed inappropriately? Inso far as Doctor [redacted] on the advice of Dr [redacted] and [redacted] thought that the behaviours were due to TLE the prescribing was not inappropriate as such. What is in question here is the question of misinterpretation of EEG's leading to inappropriate diagnoses not inappropriate treatment. This puts it in the area of medical competence. Note too that opinion was sought of Dr Mirams Director of Mental Health (whom I consider to have been a good psychiatrist in advance of his times though this does not mean that everything he said was right) who strongly endorsed the anticonvulsant treatment. The principal also endorsed the treatment saying it had produced benefits in the girls reducing the amount of emotional instability and aggression. However, the sceptic was the senior teacher and apparently much of the staff took it on themselves to criticise the wholesale exhibition of Nydrane. They turned out to be correct in that when the medication was stopped the doctor predicted sharp and massive deterioration in behaviour did not occur! This is not the first time in history where doctors have been proven wrong in their treatments and predictions and I don't think one can assume incompetence from that. If there is any incompetence it is in the fact that doctors often have to work where there is insufficient scientific knowledge and they then tend to transmute hypothesis into practice and then not unusually to move on to assertion of benefit. The fact that I would at that time have been much more sceptical is due significantly to my being an academic and researcher rather than a clinician treating a lot of patients.

6. Was Nydrane prescribed in appropriate doses? I found three references to dosage. One was in the Principals summary of all cases given the diagnosis of TLE (24). The

maximum dose prescribed (for 22 of the girls) was 500mg x three times daily or a total of 1500mg daily. Two girls had 500mg x twice daily. According to the New Ethicals 1973 Catalogue of Drugs the dosage is 1-2 500mg tablets 3-4 times daily (that is a maximum dose of 4000mg daily). Accordingly, the dosages prescribed are well within accepted dosage ranges.

Other Comments

1. Was this an experiment in the sense that we use this today. The answer to this is absolutely not. Dr [redacted] and [redacted] were acting in good faith to give treatment for what they had diagnosed with the EEG. Also, Dr [redacted] had an arguable expectation that there would be a high frequency of TLE from what some doctors were saying in the medical literature. So they were in their view only practising logical and good medical care. This point is made explicitly in a letter from the then Director of Mental Health Dr Stanley Mirams to the Head of Child Welfare dated May 15 1969. The fact that Dr Mirams thought this treatment was acceptable medical practice is tantamount to a second opinion reflecting the standard of that time.

2. The Medical Practitioners Act of that time made is clear that as long as a doctor was practicing in good faith that they could not be held to be committing malpractice. But that is your area not mine. The standards of today are much more rigorous but my view is that they cannot be considered culpable by the standards of the 1960's given the views about the role of epilepsy in behaviour. That their diagnosis was faulty in overdiagnosing TLE is a matter of law to decide not me.

3. It is most unlikely that any of the residents suffered any long term harm from the medication. It can have minor unpleasant side effects like giddiness and nausea while being administered and rarely a blood dyscrasia. It is not now used but I think that is because it wasn't very effective but most probably because there are now much better anticonvulsant drugs.

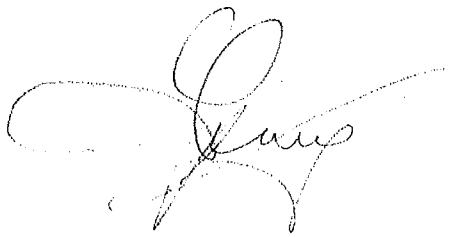
4. It is ironic but if these young women were now in the US there is a good chance that they would be diagnosed with a brain disorder and given a modern anticonvulsant (either sodium valproate or Epilim, or carbamazepine or Tegretol) as a mood stabilizer! The fact is as a recent article points out that emotional instability in children and adolescents is still poorly understood and inadequately studied. The severity of the problem is such that it still invokes all kinds of different treatments all strongly asserted by their proponents as effective. [redacted]

5. It seems from the principal's report that the girls were subject to close observation in which any significant side effects had they occurred would have been detected. There is a comment about the difficulty of getting good medical care and the need for a regular visitor to the house but this was about health care in general. There is

also a comment that Dr [redacted] was readily available if needed though at his surgery and that the district nurse was visiting regularly and considered helpful.

6. This may not be relevant but reading the annual reports I was struck by the high standard of caring and understanding of the principal and senior teacher and the trial of home visits. All of this suggests that the care given to these very difficult young women was pretty good for the times and some might argue as good as now.

In my view these points would cover all the cases and I decline to read all the cases or comment on them individually unless there is something not covered or a major departure from the above.



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