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Challenges of Litigating Mild Traumatic Brain Injury

2016 Traumatic Brain Injury Conference

January 29, 2016

Dale Orlando and Alison Burrison

Objective

- Prove impairments are caused by organic injury
- Prove the impairments are permanent
- Prove that the impairments impact on function

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Think Like a Juror

- You know nothing
- Medical science knows everything
- X-rays, MRI and CT are infallible
- The patient/plaintiff looks and sounds fine

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Challenges

- Injured party looks healthy
- No objective evidence of injury
- Experts rely on self report in making diagnosis
- Neuropsychology results are open to interpretation
- Equally qualified experts disagree on diagnosis, causation and functional impact

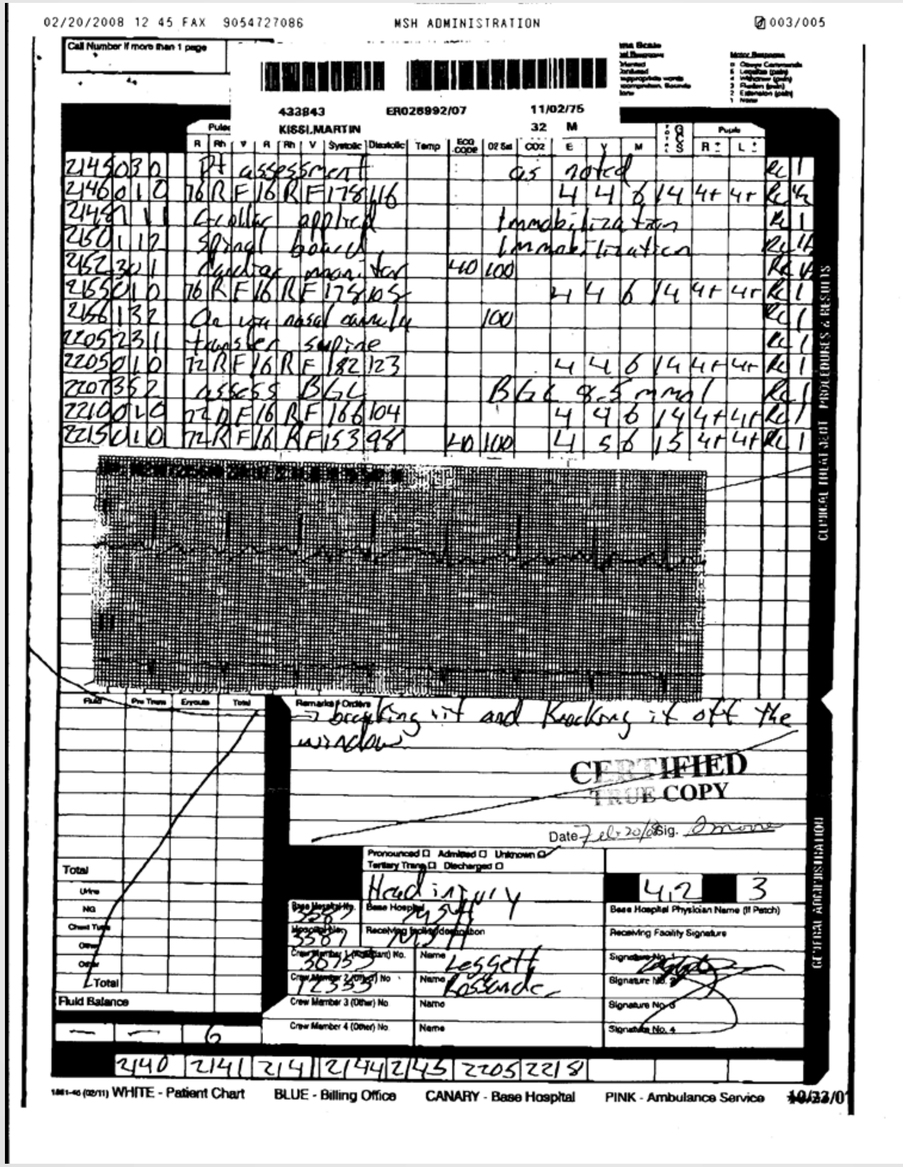
Standard Defences

- Any symptoms are emotional and can be rectified by proper treatment
- The plaintiff is exaggerating or malingering
- Any impairments are as a result of pre-existing problems or a post accident event
- The plaintiff has bought into disability

Strategies

- Look for physical evidence in the “early records”

Use Ambulance & Hospital Records



02/20/2008 12 45 FAX 9054727086 MSH ADMINISTRATION 003/005

433843 ER026892/07 11/02/75
KISSI,MARTIN 32 M

Head injury

Remarks / Orders: breaking it and knocking it off the window

CERTIFIED TRUE COPY
Date 2/6/20/8 Sig.

Base Hospital Physician Name (If Patch)

Receiving Facility Signature

Crew Member 2 (Driver) No. 3515 Name Leggett

Crew Member 3 (Other) No. 7335 Name Lasonde

Fluid Balance

WHITE - Patient Chart BLUE - Billing Office CANARY - Base Hospital PINK - Ambulance Service

CLINICAL TREATMENT PROCEDURES & RESULTS

CRITICAL ADMINISTRATION

GCS = 14

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Document Initial Observations

Patient Call Report
Confidential When Completed

ornge

Leaders in Transport Medicine

ADMINISTRATION

Surname: [redacted]		**Call Date:** 2015-03-02	**Service Name:** ORNGE
Given Name: [redacted]		**Comm Center:** OCC	**MT#:**
Mailing Address: [redacted]		**Patient #:** [redacted]	**Trip #:** [redacted]
City / Town [redacted]		**Veh #:** CGYNH	**Veh Level of Care:** Critical Care - 07
Province: ON		**Base:** 7799 - Toronto (Primary)	**Status:** At Base - 0
Country: Canada	**Postal Code:** [redacted]	**WS to Scene:** NA (Aircraft)	**WS to Dest:** NA (Aircraft)
Gender: Female	**Weight:** [redacted]	**Priority - Dispatch:** 4 - Urgent	**Call Type:** Modified Scene
Date of Birth: [redacted]		**Priority - Return:** 04 - Urgent	
If patient is a child **guardian's name:** [redacted]		**CTAS - Dispatch:**	**CTAS - Return:** 2 - Emergent
# of Patients: 1	**Patient Seq #:** 1	**Deceased:** Not Applicable	
OHIP Card #: [redacted]	**Other #:**	**On Scene GPS:** *Lat* *Long*	

…Significant damage to vehicle +++++...pt unconscious. Immobilized at scene & pt regained consciousness en route to Trenton hosp (reportedly GCS 13-14)…Vomited x 1 & incontinent of urine...

CLINICAL INFORMATION

At ~18:00 this evg, pt was the restrained rear seat right side passenger in a vehicle travelling at unknown speed when it collided with another vehicle head on. Significant damage to vehicle +++++. O/A of local EMS, pt unconscious. Immobilized at scene & pt regained consciousness en route to Trenton hosp (reportedly GCS 13-14). Shortly after arrival in ER, pt became decreased LOC with eyes deviating up & to the right. Vomited x 1 & incontinent of urine. No seizure activity noted. Pupils 3+ PERL bilat. Intubated @ 18:40 with Sux, Propofol & Roc. Fast negative, no further imaging done. Hosp tx: 2xPIV's, ETT, Lab work, OG, CXR. For transfer to HSC ER Trauma team. Uneventful transport. Transferred care to TTL & report given.

Traumatic Injury Site/Type

1 Trauma Injury: Location - Head/Brain/Scalp - 10, Injury Type - Blunt - 34, Mechanism - MVC - 58

Relevant Past History

Communicable Diseases - None

Previously Healthy

Medications

Home Rx: Prior to Hospital Visit/Admission

NO Medication

Hospital Rx: Prior to Ornge Arrival

Fentanyl (Sublimaze)
Propofol (Diprovan)
Rocuronium
Succinylcholine (Anectine)

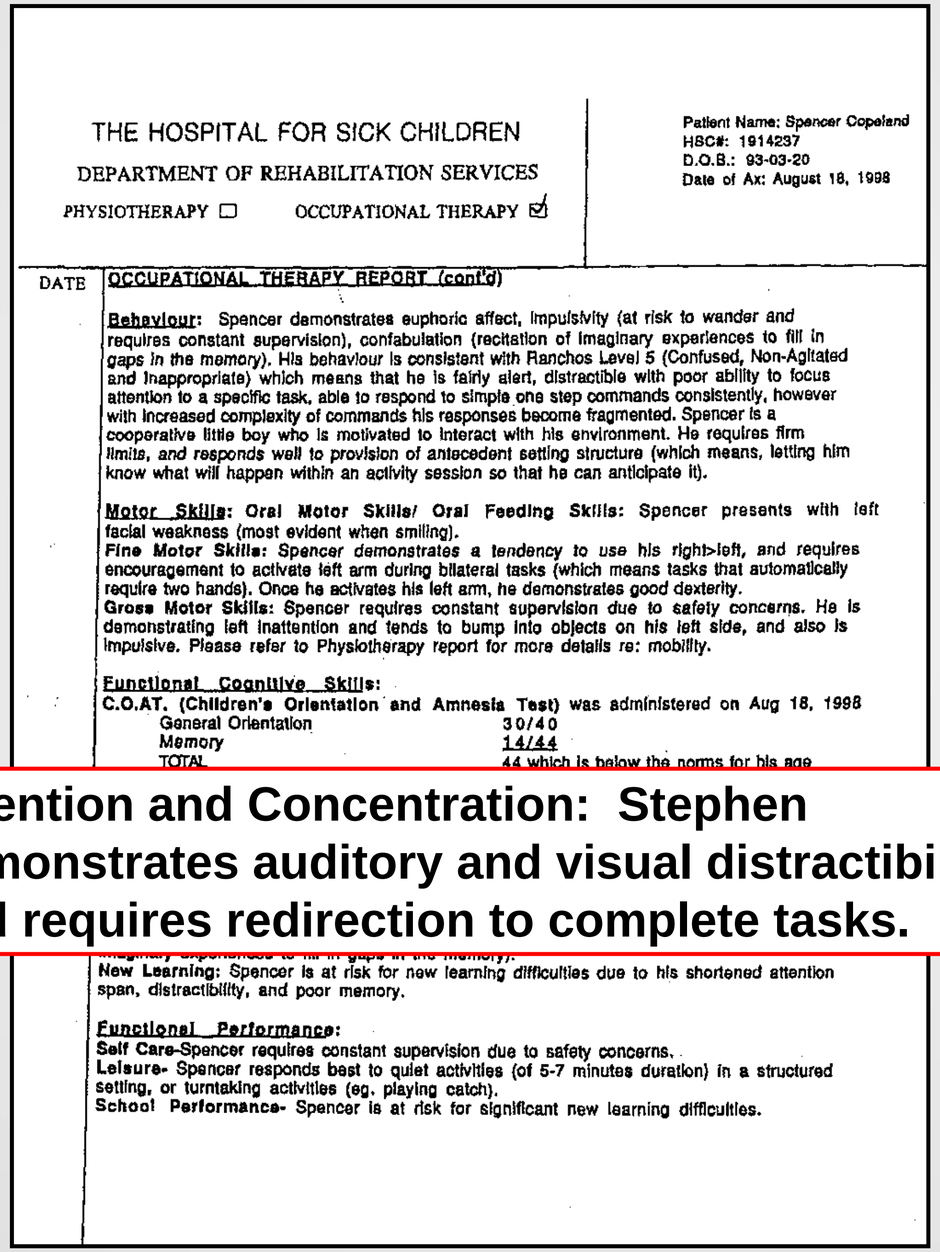
Allergies

NKDA

Strategies

- Document in detail the evolution but overall consistency of symptoms

Use the Later Records to Show Consistency of Symptoms



THE HOSPITAL FOR SICK CHILDREN

DEPARTMENT OF REHABILITATION SERVICES

PHYSIOTHERAPY ☐ OCCUPATIONAL THERAPY ☑

Patient Name: Spencer Copeland
HSC#: 1914237
D.O.B.: 93-03-20
Date of Ax: August 18, 1998

DATE

OCCUPATIONAL THERAPY REPORT (cont'd)

Behaviour: Spencer demonstrates euphoric affect, impulsivity (at risk to wander and requires constant supervision), confabulation (recitation of imaginary experiences to fill in gaps in the memory). His behaviour is consistent with Ranchos Level 5 (Confused, Non-Agitated and Inappropriate) which means that he is fairly alert, distractible with poor ability to focus attention to a specific task, able to respond to simple one step commands consistently, however with increased complexity of commands his responses become fragmented. Spencer is a cooperative little boy who is motivated to interact with his environment. He requires firm limits, and responds well to provision of antecedent setting structure (which means, letting him know what will happen within an activity session so that he can anticipate it).

Motor Skills: Oral Motor Skills/ Oral Feeding Skills: Spencer presents with left facial weakness (most evident when smiling).
Fine Motor Skills: Spencer demonstrates a tendency to use his right>left, and requires encouragement to activate left arm during bilateral tasks (which means tasks that automatically require two hands). Once he activates his left arm, he demonstrates good dexterity.
Gross Motor Skills: Spencer requires constant supervision due to safety concerns. He is demonstrating left inattention and tends to bump into objects on his left side, and also is impulsive. Please refer to Physiotherapy report for more details re: mobility.

Functional Cognitive Skills:
C.O.AT. (Children's Orientation and Amnesia Test) was administered on Aug 18, 1998

General Orientation	30/40
Memory	14/44
TOTAL	44 which is below the norms for his age

Attention and Concentration: Stephen demonstrates auditory and visual distractibility and requires redirection to complete tasks.

New Learning: Spencer is at risk for new learning difficulties due to his shortened attention span, distractibility, and poor memory.

Functional Performance:
Self Care-Spencer requires constant supervision due to safety concerns.
Leisure- Spencer responds best to quiet activities (of 5-7 minutes duration) in a structured setting, or turntaking activities (eg. playing catch).
School Performance- Spencer is at risk for significant new learning difficulties.

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Strategies

- Comment on force of impact/property damage if applicable

Photographs of Badly Damaged Vehicle

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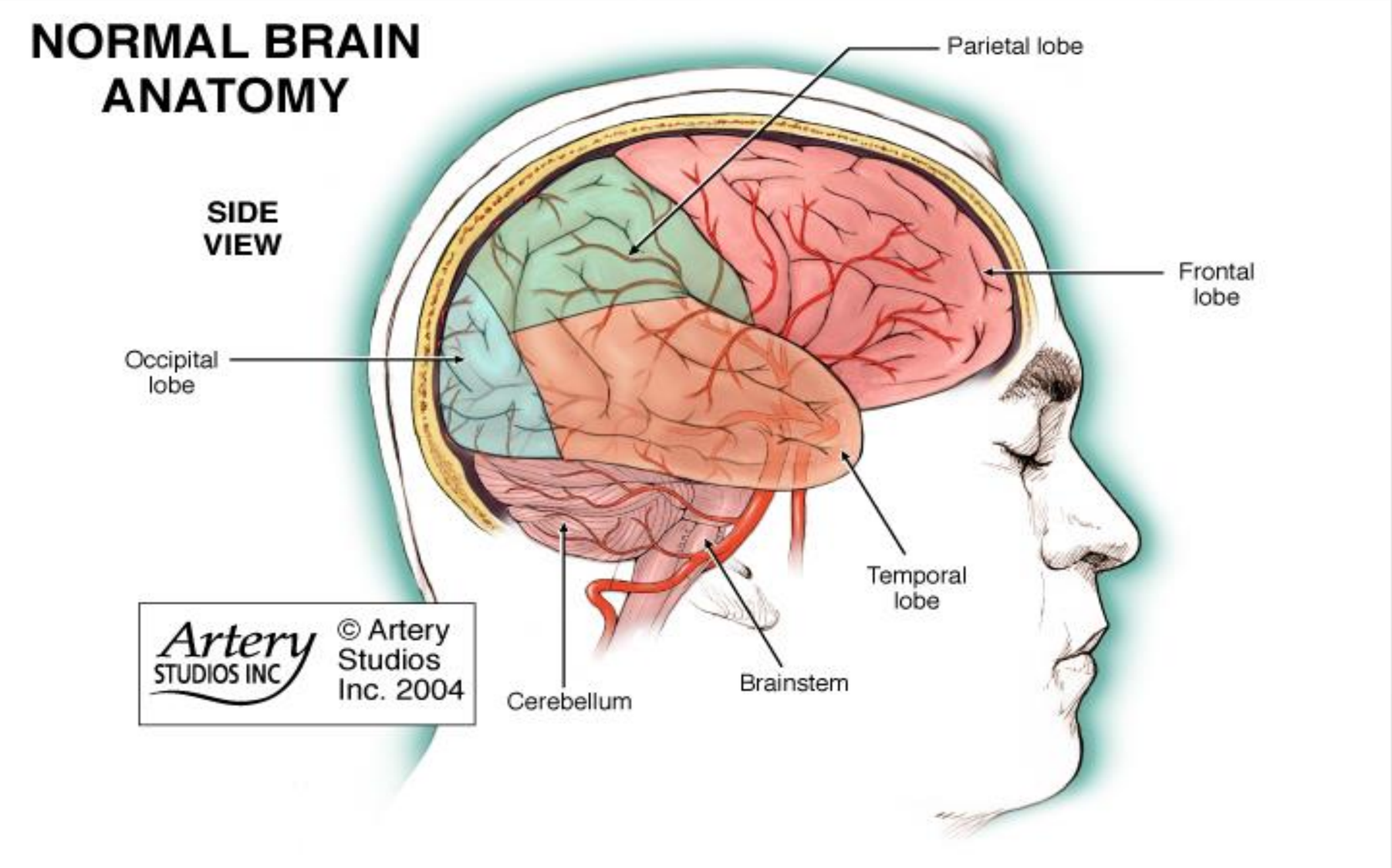
Strategies

- Explain the mechanism of injury

Use Illustrations and Models to Explain Anatomy, Function and Mechanism of Injury



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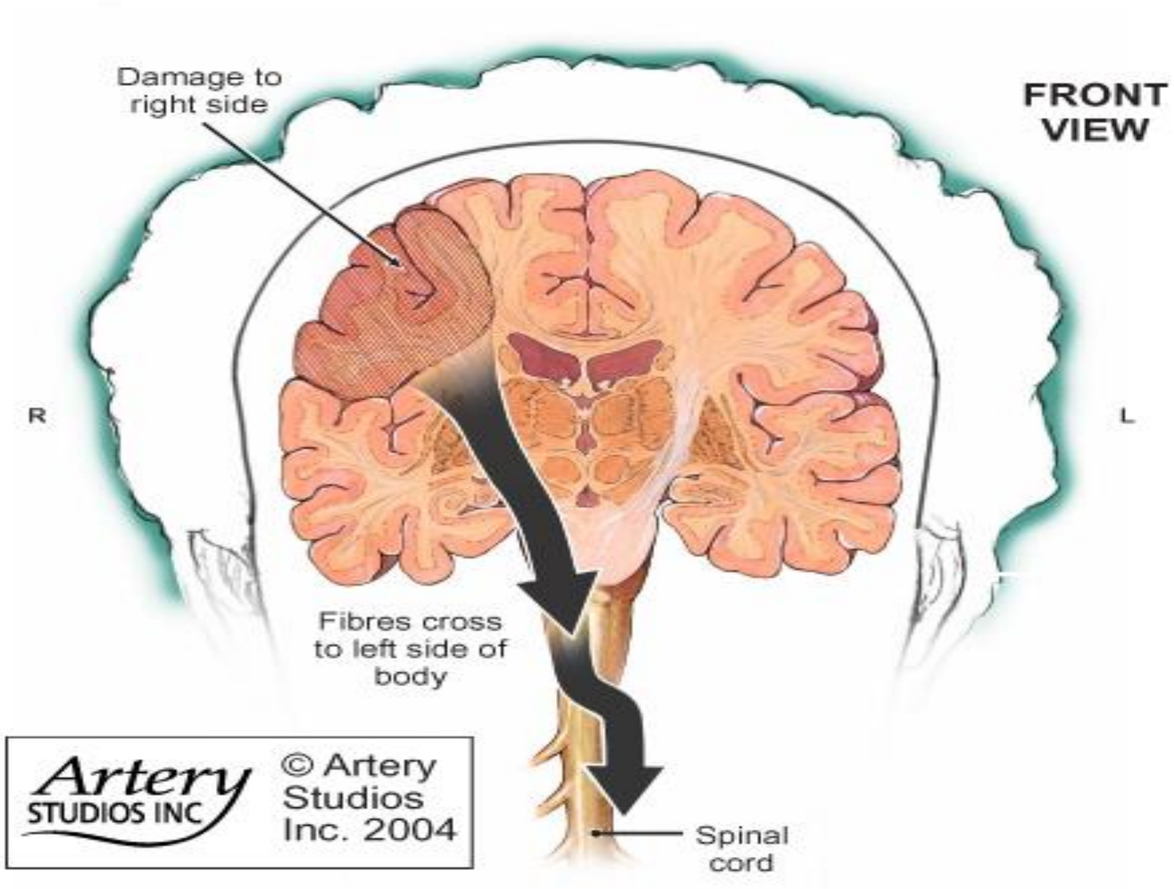
RIGHT-SIDED BRAIN INJURY AFFECTS LEFT SIDE OF BODY



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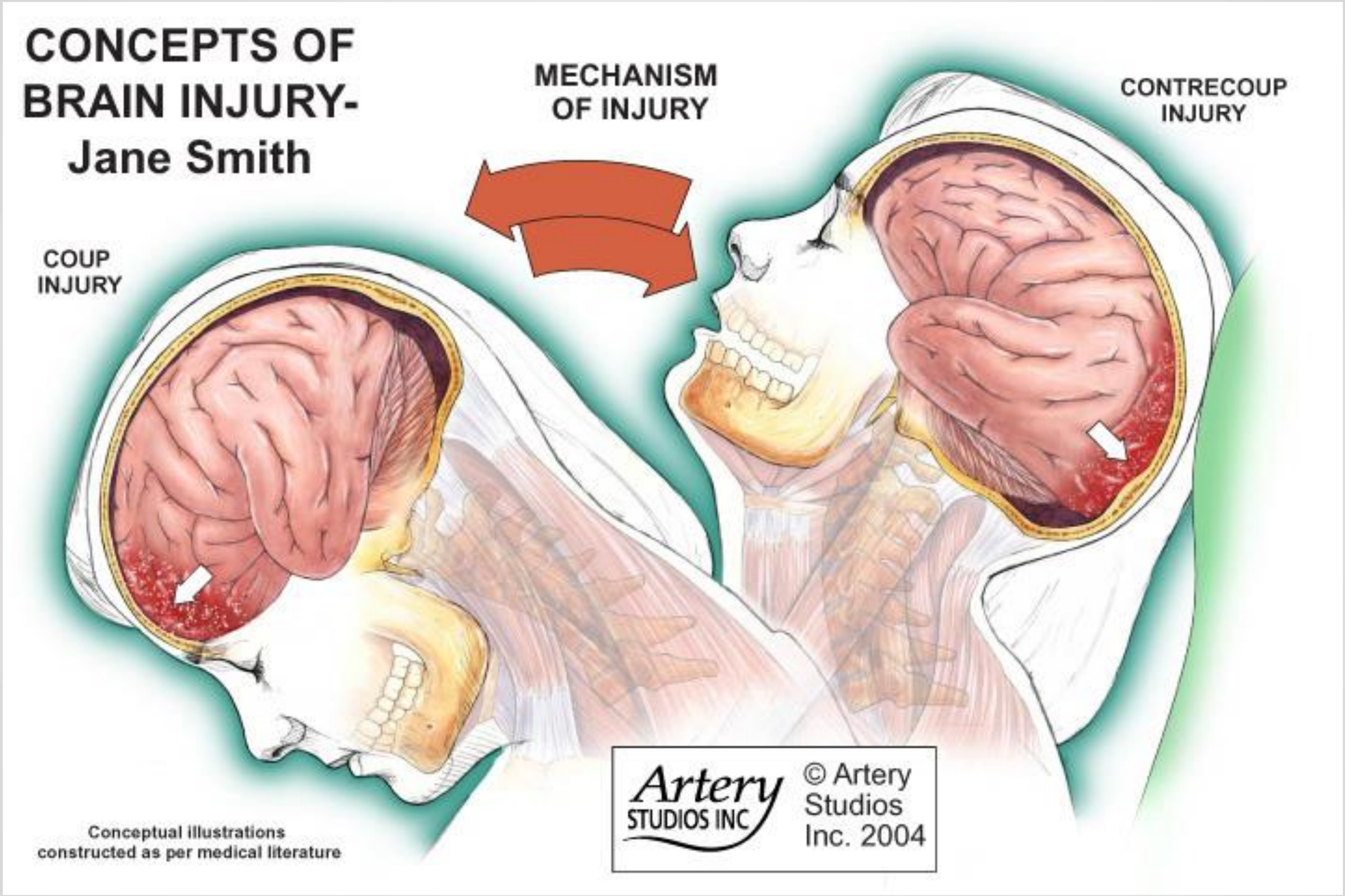
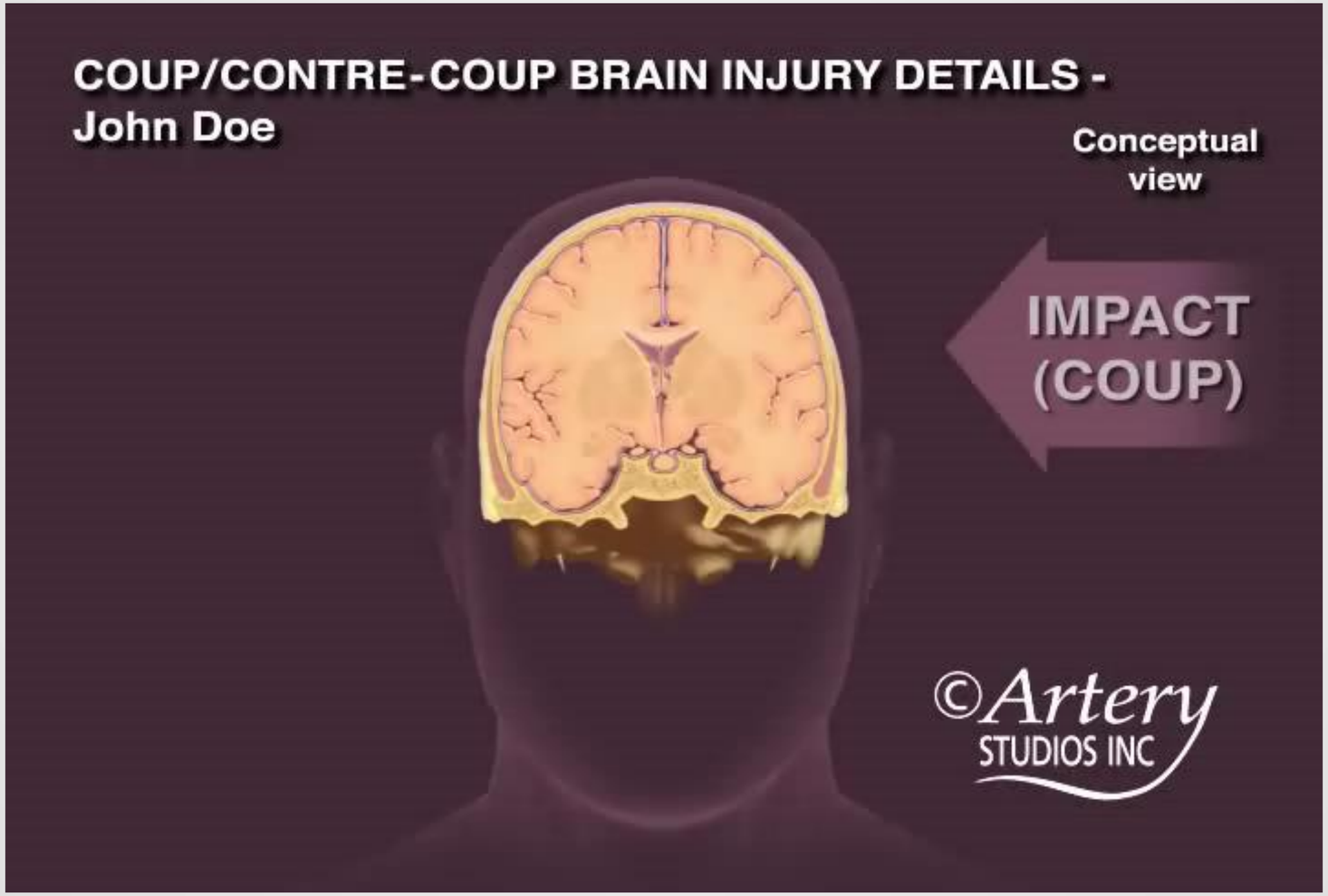
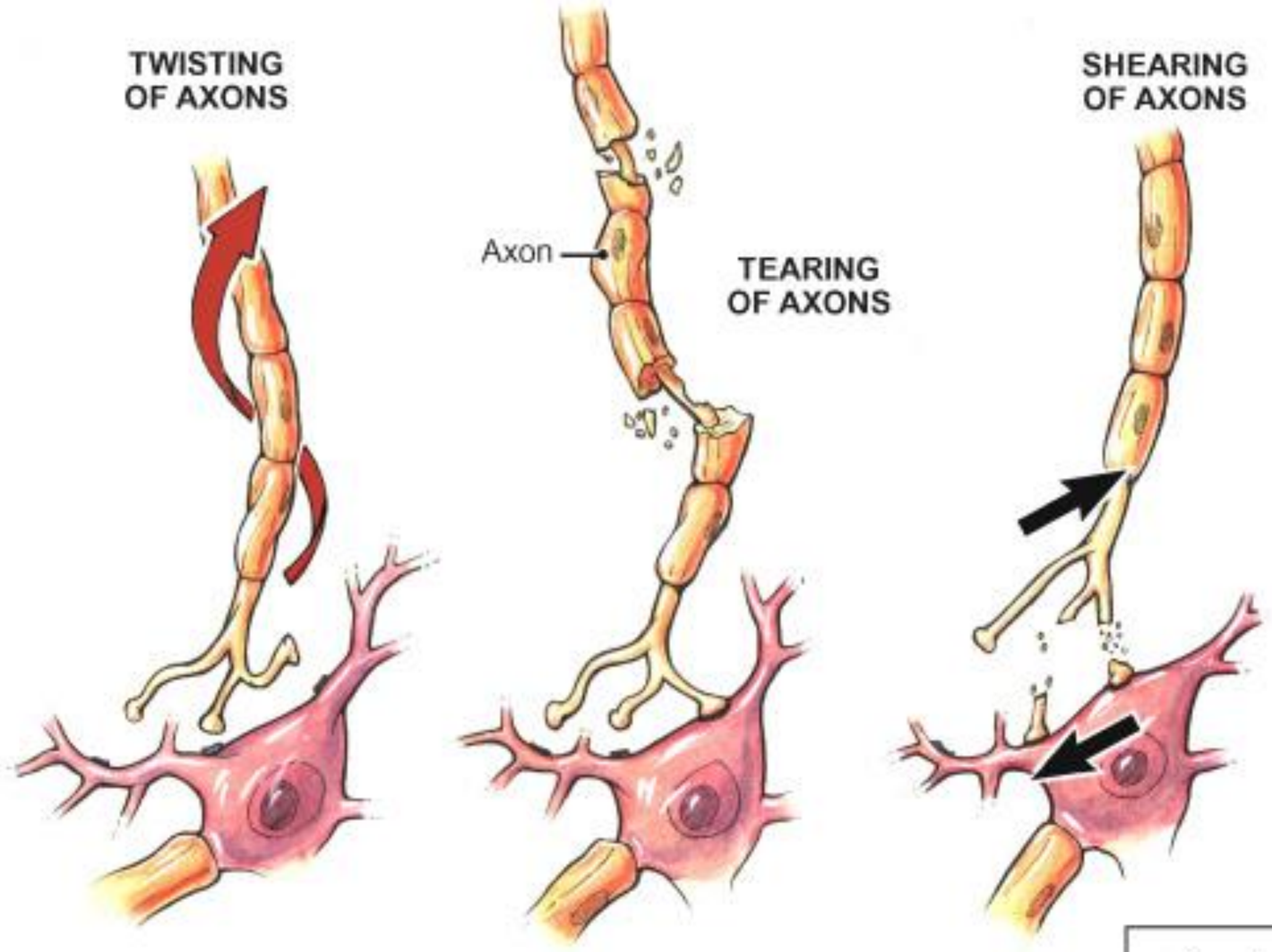

CONCEPTS OF BRAIN INJURY-
Jane Smith
MECHANISM OF INJURY
CONTRECOUP INJURY
COUP INJURY
Conceptual illustrations constructed as per medical literature
Artery STUDIOS INC
© Artery Studios Inc. 2004

Video: Coup/Contre-Coup Brain Injury

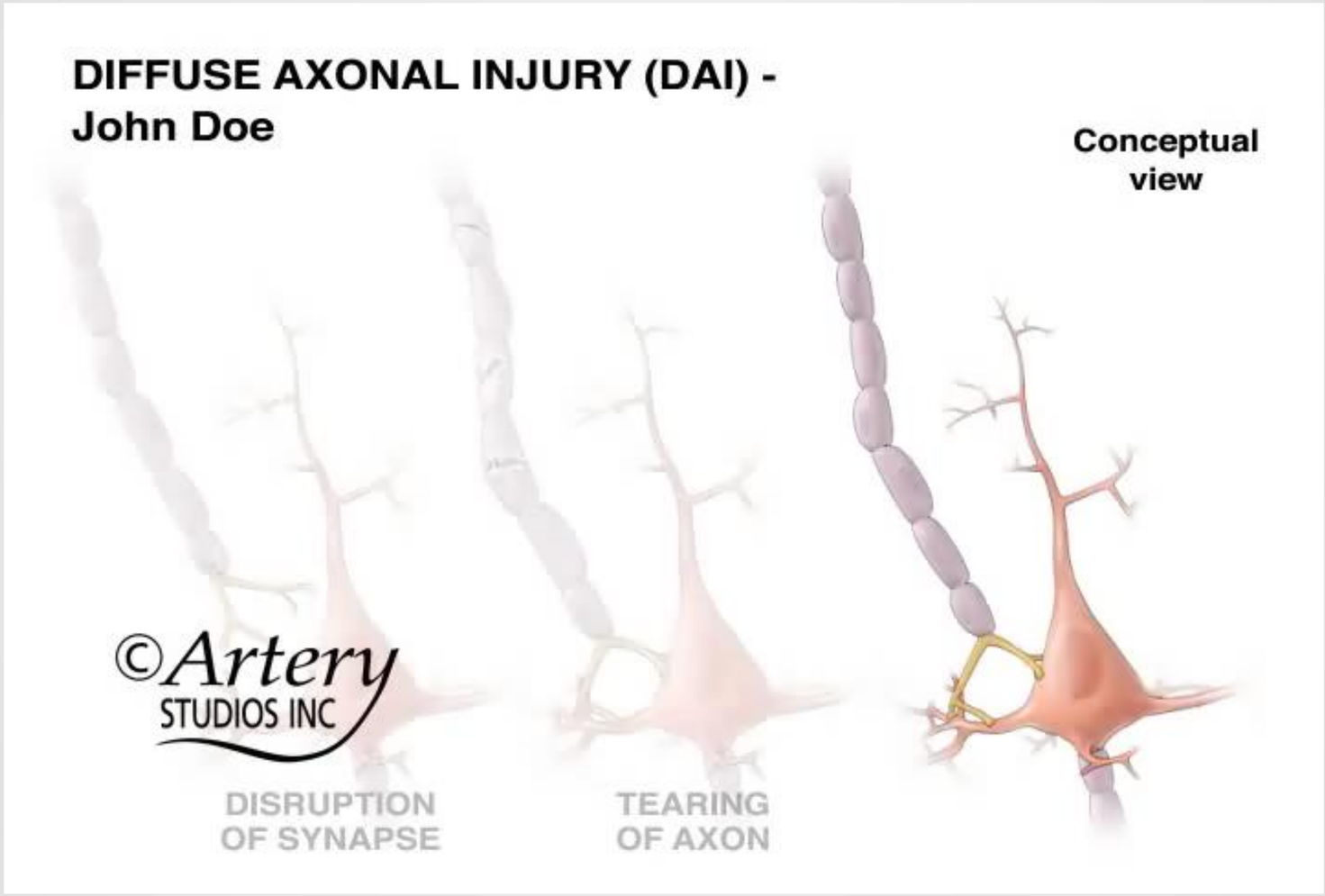


DAMAGE TO AXONS



Video: Diffuse Axonal Injury

Video: Diffuse Axonal Injury- Breaking of Axon



Strategies

- Experts explain negative CT scans and MRI
  - Imaging techniques are still in their infancy
  - Negative scans expected in cases of mild and moderate TBI

Strategies

- Differentiate any pre-accident symptoms
- Compare and contrast pre-accident success with post-accident inability to function in similar roles
- Rely on reports of family

QUESTIONS

THANK YOU