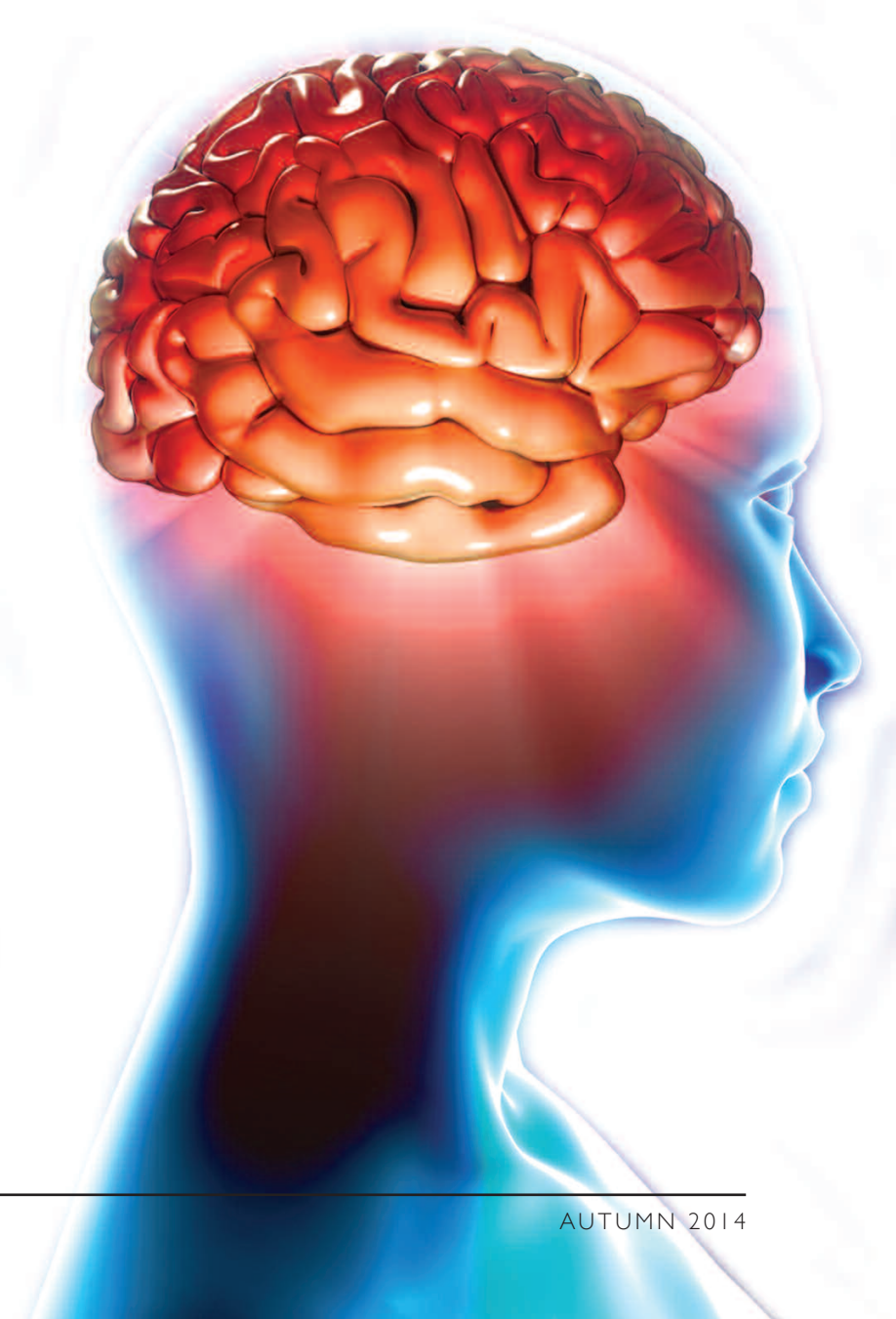
'The Long Range Forecast' - The Challenges of the Care Expert in Brain Injury Cases

"At one point I was apparently convinced I had to file an article for The Daily Telegraph ghosting for Gary Lineker who was living under my hospital bed while I was sharing it with his wife."

- James Cracknell from 'Touching Distance'



Introduction

A Consultant Neurologist I once worked with used to say that he loved working with the brain because however experienced he became he would never be in a position where he knew all there was to know about his chosen field. The human brain, its capabilities and seemingly infinite capacity continue to intrigue and baffle scientists and clinicians alike. This is one of the reasons it captured my interest after qualifying as an Occupational Therapist in 1994 and why I myself spent over 10 years as a clinical specialist in the area of Neurology.

In litigation, the most severe and disabling injuries are often those which involve the brain or spinal cord. Whereas injuries to the spinal cord and indeed injuries to the limbs are more tangible and give rise to largely predictable symptoms, the sometimes subtle and unpredictable symptoms of brain injury can leave the assessor, treating clinicians and the family somewhat confounded. Those who have suffered mild to severe traumatic brain injury but whose bodies have physically fully recovered from their injuries, leaving them looking 'normal' to the unaware, often present the biggest challenges of all.

The Identification of Need

I have been an occupational therapist (OT) for 20 years and an expert witness for 10 of those years. Regardless of the number of clients I have seen and treated following brain injury, I find this high functioning client group, (which in litigation we sometimes refer to as 'walking wounded' or 'walking heads'), leaves me regularly faced with the battle between facilitation of independence and the encouragement of dependence.

Invariably the majority of head injured claimants are young people who have been involved in accidents where cars have been driven at speed and who, as a consequence of the index event, have been severely injured in the prime of their lives. The difficulty in making adequate provision for their future via their award for damages is that they have suffered, what I consider, an 'arrested development', as young people who were still in education or at the start of their careers. We often do not know what they would have been intellectually and functionally capable of, but for the injury, and have to make educated assumptions about whether they would have had partners, children, stable careers and active hobbies. Some of those who sustain traumatic brain injury are older of course and have stable careers and family lives and then the impact can be more demonstrable even where the management of their symptoms is still far from straightforward.

Injured young people tend to have the drive and motivation to get well and invariably want to continue life as they would have had they not suffered the injury. This high level of determination and desire to be 'normal' again can mask underlying behavioural, intellectual and cognitive symptoms. It is accepted, and was certainly my clinical experience that our National Health Service does not have the capacity to provide long term rehabilitation to this client group and often they are discharged home with very little advice and support once it is deemed they are functionally independent in basic daily living tasks.

Beverley Turner, James Cracknell's wife puts it succinctly in their description of their experience: *"Sadly the window of opportunity to maximise improvement is often neglected due to inadequate NHS resources in the UK. The majority of patients are simply returned to their shocked and frightened families where they have become an impatient, confused and angry stranger in their midst."*

(From: Touching Distance, James Cracknell and Beverley Turner 2013)

As care experts we often have but one opportunity to try and 'get it right' when it comes to making an assessment of the injured party's needs, whether instructed by the solicitors for the Claimant or on behalf of the Defendant. On occasion we may have the opportunity to re-visit the Claimant or may have the benefit of medical evidence, information from case managers, treating therapists and support workers with which we can build a picture of their future needs. The statements and evidence of the family usually offers the most useful insight.

"*Families can provide valuable insights into the patient's character, choices and ambitions, as well as important information on the presentation of difficulties in the home setting. This is essential in initial assessment, and in the monitoring of rehabilitation gain, to minimise under-reporting of difficulties when the brain-injured person lacks insight*"

(From: Rehabilitation following acquired brain injury: national clinical guidelines, BSRM).

In truth however, much of what we recommend in our subsequent reports for the Court will be based on the snapshot we get at assessment interview and our own clinical experience and expertise.

Facilitation is Key

So what, in terms of 'care' does this brain injured person require? They may be back at work, going to college or university or have found new employment by the time I get to see them several months, and maybe years, after the brain injury. How can they best be supported to achieve the most in life whilst seeking to prevent them from placing themselves or their dependants in any danger, losing close relationships or failing in their chosen studies or employment? Psychological evidence is often paramount in determining the extent of any behavioural, emotional or intellectual deficits. Identifying appropriate support systems and levels of support to assist the Claimant in managing these symptoms is much harder.

As occupational therapists our core skills and training are focussed around enablement and re-enablement – assisting people with disability, whether mental or physical, to achieve their maximum potential.

'The purpose of occupational therapy is to enable people to fulfil, or to work towards fulfilling, their potential as occupational beings. Occupational therapists promote function, quality of life and the realisation of potential in people who are experiencing occupational deprivation, imbalance or alienation. They believe that activity can be

an effective medium for remediating dysfunction, facilitating adaptation and recreating identity.'

(From:The College of Occupational Therapists Code of Ethics and Professional Conduct 2010)

We aim to promote independence, seeking ways of enabling the individual to manage a task either through facilitation or adaptation rather than provision of care. Where a disabled or disadvantaged individual cannot manage daily living tasks without risk or detriment to themselves, the provision of care is of course indicated but always with a focus on allowing them as much independence and autonomy as possible. When considering the high functioning brain injured client our focus remains the same. What can they achieve and what do they need to facilitate this safely and successfully?

The Purpose of our Recommendations

The relatively 'hands off' approach OTs often use can jar with Claimant instructed parties when they feel more substantial care packages and formal support may be indicated. Obviously in terms of compensation Claimant litigators are understandably committed to obtaining the maximum amount possible for their clients.

Our role and commitment to the Court as a care expert in civil litigation is to:

'the principle of the law is that compensation should as nearly as possible put the party who has suffered in the same position as he would have been in ifhe had not sustained the wrong.'

(Lord Blackburn, quoted by Lord Scarman 1980).

Many solicitors feel that this is done through care and case management provision and in some cases where physical injuries or severe psychological disturbance are paramount, big care packages are entirely justified and necessary in order to offer the injured party any quality of life. In the cases of the 'walking wounded' head injury it is not so straight forward; although some level of support may be indicated there is a fine balance between facilitation and over provision in terms of enabling them to live a normal life.

As already noted, the care needs of individuals who fall within this group are unpredictable and their symptoms need to be carefully understood. There is also the issue of engagement with services and, where the client has a history of rejecting care, we need to understand what support they will engage with and how care can best be provided.

Recent Case Examples

I attended Court at the end of 2012 and gave care evidence on behalf of the Claimant, a young man injured at age 18 when he was struck by a car. He suffered orthopaedic injuries as well as a severe brain injury, requiring craniotomy. He was of Bangladeshi origin but had been living with his parents and siblings in the UK since the age of two. The difficulties of the case centred on the Claimant's inconsistencies in presentation. He had apparent marked cognitive difficulties causing him to fail even simple tests, lose his way when out and he appeared to be forgetful in everyday life. Contradictory to this, he was apparently able to study at college, use bus routes alone, make social plans and execute them, and use social networking sites successfully.

The evidence of the Defendant Experts was that he was much more capable than he would appear and that he had exaggerated his symptoms with Experts to maximise his claim. The Claimant's evidence acknowledged the inconsistencies but was able to prove that he had genuine day-to-day difficulties with functional tasks and lacked insight at times making him vulnerable. What transpired at Trial was that over the course of the three years we as Expert Witnesses had assessed this young man he had changed and so had our views, but essentially he was never going to be able to live the life he had once planned. He had been provided with substantial therapy, support work and case management which had facilitated his understanding of his difficulties and the management of his daily life. However it was largely agreed that in the long term the care and support he would most benefit from would be at a low level allowing him autonomy to seek independence socially and to facilitate potential employment of some kind.

The Judge in the case took a great deal of time trying to understand the issues and wrote a lengthy judgement which took some six months to publish and was over 100 pages in length. He concluded that the Claimant's abilities and long term functional potential was difficult to agree but that some further therapy and then relatively low level care (in the region of 15 hours per week), and case management would always be required to maintain his safety and allow him to achieve employment and enjoy a good quality of life. Justice Stuart-Smith stated:

'The purpose of the future care regime should be to provide sufficient support to enable (the claimant) to pursue a

structured and constructive existence so far as possible, reinforcing constructive routines and being available to assist when he is confronted by the new, the unfamiliar or the complex'

(Mr Justice Stuart-Smith)

I have many other active 'walking head injury' cases at the time of writing this report where I am acting on behalf of the Claimant or Defendant as well as under joint instruction. It concerns me in some of these cases that case managers and therapists instructed under the Rehabilitation Code (Ministry of Justice 2007), have instigated large packages of care and support for these individuals which in my view, although well meaning, have fostered dependence. Examples include skilled support workers accompanying the Claimant to the shops when they regularly and capably use public transport and visit town alone, or support workers taking fully physically fit individuals to play badminton or swimming which they could do with friends or family. These tasks are being encouraged and undertaken rather than seeking to facilitate vocational or domestic independence as priorities. My role then as a Court appointed Expert, is to give my honest and considered views on their future needs, and this can sometimes be contradictory of the case manager and suggests a reduction in care and support. With any of my recommendations, it is of course imperative that I can justify my views and ultimately stand my ground should discussions with the opposing care expert be required or should the case ever run to trial.

Providing for the Essentials

In my view there are some basics which can be argued in most brain injury cases. Firstly, in the first few years after injury and post settlement, good quality brain injury case management is required, sourced from a CMSUK (Case Management Society UK) registered company and who is preferably a member of BABICM (British Association of Brain Injury Case Managers). The Case Manager's role is not only to organise any therapy and care support but also to act as an advocate for the client and family in trying to understand their situation post injury and how best to cope with it. They also have an essential role in training and supporting employed carers in delivering the optimum support for the claimant.

Secondly, appropriate therapy is often required, and invariably includes some psychological therapy. Specialist occupational therapy, whether this is

instigated to facilitate domestic competence or a return to study or vocational activity is also often vital with vocational rehabilitation paramount. This intervention should be time limited. The OT's role may also include training and education of the individual or family regarding brain injury management.

Finally there may be a need for employed care usually in the form of brain injury support workers, either via a specialist agency or directly employed. The level will need to be decided but will almost always commence at a higher level and be gradually reduced as therapy is completed and the optimum levels of functional independence are reached. It is likely that the care recommended will need to be available flexibly given the nature of these individual's needs.

Finally, there will always likely be some low level of additional gratuitous support required whether this is provided by a partner, family or close friends. The unpredictable nature of the psychological symptoms and the changes in personality or cognitive abilities will require those closest to the individual to be sensitive, patient and able to help their loved one deal with day to day challenges or crises which may occur. Family or a Deputy of the Court may also be required to manage the injured party's financial arrangements.

Conclusion

The honest truth (and the whole truth) will always be that the apparently high functioning brain injured client will always present challenges in predicting reasonable needs and the only measure of whether we as Care Experts are 'getting it right' will be in the achievements of these individuals some way down the line. Many of these Claimants will choose not to employ or participate with formal care and support after settlement of their claims and will choose their own path, but for the Expert Witness we need to remember that 'getting it wrong' could leave this already vulnerable group at risk of further harm.

"I am saddened but not surprised to discover that many studies of British 'offender populations' conclude that 50% of inmates have a TBI. In the UK alone that equates to 40,000 imprisoned men with irreversible brain damage"

(From: Touching Distance James Cracknell and Beverley Turner)

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