



Issues in Litigating “The Invisible Injury:” Pre-senting Clients in Traumatic Brain Injury Cases

by Kent Emison

Though thousands of them occur in America every year, traumatic brain injuries often go undiagnosed and untreated. Brain injuries change people so much that it is as if the original person dies and a new person emerges to themselves, their friends and family.

We have seen this time and again in our own practice, representing clients who suffer the consequences from a traumatic brain injury, or TBI. This article will look at the themes that often run through these cases, and ways to make the most out of these cases and get the optimal recovery for your client in his or her situation.

Basic facts about TBI

The most important thing to remember about TBI cases is that traumatic brain injuries are the only type of brain injuries. There is no such thing as a brain injury that does not create trauma. As such, there a number of themes that should control the handling of this sort of case from the initial client interview through the final close of the case. There is no such thing as a “mild” TBI.

Those common themes include:

- Pain and suffering
- Mental anguish
- Depression
- Fatigue, nightmares
- Loss of independence
- Loss of family
- Loss of enjoyment of life
- Loss of self-worth
- Loss as a friend
- Loss of choice
- Loss of manhood/womanhood
- Loss of intimacy
- Loss of sleep

Each one of these central themes

can be elaborated upon at great length from negotiation to mediation through trial. It goes without saying that just like each brain injury, each case is distinct – the above list is only meant as a list of the most common themes that tend to come up in these types of cases, from our experience working this type of litigation.

Proving TBI damages

A common misperception is that TBI victims quickly recover from their injuries. Clinical research, however, has shown that the consequences of TBI are serious and cause lasting problems.¹ Each year, more than a quarter-million TBI victims suffer prolonged disabling injuries and countless numbers go unaccounted.²

A Scottish study examined TBI patients one year after injury and found that, not only were most survivors of *severe* TBI disabled, but incidence of “disability was also common and occurred at a similar rate in survivors of *mild* and moderate [traumatic brain] injuries.”³ Of 362 “mild” TBI patients identified in the study, 55 percent reported injuries at a moderate or more severe injury level.⁴

A follow-up study examined the same patient population at five to seven years after injury.⁵ The authors found that overall rate of disability was “very similar to that observed at one year.”⁶ Though some subjects reported an improvement to a state of “good recovery,” a majority of participants reflected a “persistence of disability from the earlier assessment.”⁷

The fact is that even when a proper examination is undertaken, the results of testing may be negative despite the existence of brain injury.

When your client has suffered a closed head injury, his or her injury may not be apparent based upon his or her outward appearance. They may have cognitive, physical and emotional problems, but exhibit no disfigurement, limp or scars. As a result, the attorney is placed in the position of asking a jury to believe something that they cannot see.

Also, when a patient is sent to the emergency room, the physicians there are looking for life-threatening conditions and not the full array of brain injury possibilities. One 2008 study even found that 56 percent of mild TBI cases identified by personnel in the study did not have a documented mild TBI-related diagnosis in their health record.⁸ Despite the appearance of “normalcy,” the patient can complain of fatigue, headaches, muscle stiffness and tension, insomnia, nightmares, slowed thinking, poor memory or loss thereof, poor impulse and anger control and impaired judgment. While not instantly thought of as the result of a TBI, these symptoms do indeed come with what is often referred to as “the invisible injury.”

Putting together a credible narrative that your client has suffered an injury, therefore, can be challenging. This should be attempted with the assistance of demonstrative aids. Your goals in using demonstrative tools should be to a) show the extent of the physical injury, b) highlight the violence of the traumatic event; and c) demonstrate that your client suffered neuropsychological deficits as a result of the traumatic event. You should aim to correlate the violence of the traumatic event in question with specific brain injuries at this stage.

issues in litigating continued on page 24



Before this TBI case goes to trial, you'll need to determine whether the item in question will serve as a piece of evidence or simply as a demonstrative aid. If counsel seeks to introduce it into evidence, it should be marked as such before its introduction. One absolute "must-do" is to evince to the jury the violence involved in the accident bringing about the injury.

One way to do so is to provide photographs of the scene of the accident and, if it is an auto accident, photographs of the vehicles involved – both interior and exterior. If there are no photographs of the vehicles at the scene available, make certain to take photographs of the vehicles wherever they might have been moved. If the windshield is cracked make sure you have close-up photos that can be enlarged and can prove the impact of the skull. You should always introduce photos of the interior of the vehicle and the condition of the other vehicle in a motor vehicle crash case.

Demonstrating the mechanics of

the collision is also critical. Your accident reconstructionist and biomechanical engineer in this type of case will be helpful in creating an animation or graphic to illustrate how the accident happened. The biomechanical engineer will also be able to create a graphic or animation to show the mechanics of the injury to your client's body.

Explaining the anatomy of the brain is done well when executed through the use of models and medical illustrations. These tools are useful for presenting medical concepts or procedures that may be difficult for the jury to understand. Using these aids, the treating physician or neuropsychologist will be able to provide the jury with insight as to the mechanics of the brain and the results of the injury. There are also digital tools and tests that will greatly enhance your TBI case.

Positive imaging studies and Diffusion Tensor Imaging

Cases that are supported by positive images of brain injury are much less challenging than those

that aren't. There are several imaging studies that are generally used to rule out or confirm intracranial injuries. In addition to findings demonstrated in imaging studies, there are likely additional numerous, microscopic, widespread, undetectable injuries. The absence of positive findings on imaging studies does not mean that TBI is ruled out.

X-rays are not used for diagnosing intracranial injuries. CT (CAT) scanners are widely available and used in many health care facilities across the country. CT's are typically taken to evaluate patients for intracranial hemorrhage. They can detect significant intracranial injuries, but are not as effective as MRI's to detect more subtle injuries. MRI's have many times the resolution of CT scans.

As the first studies are performed to rule out or confirm "serious" not "subtle" brain injuries, MRI's are not typically performed during initial critical care periods. MRI's are often performed at later dates to determine the cause of later recognized behavioral

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or cognitive abnormalities. But by that time, subtle initial brain injuries may have resolved to the point where they are no longer detectable. Even if MRI's were performed and interpreted as negative for acute injury, it doesn't mean brain injury is ruled out.

The most thorough test in this area would be a state-of-the-art MRI with Diffusion Tensor Imaging (DTI) and a special TBI protocol. Diffusion Tensor Imaging is being performed by those neuroradiologists who are familiar with its applications. PET scans and SPECT scans can also be effective diagnostic tools for detecting subtle traumatic brain injury, with PET scans being the more sensitive. X-rays, CTs and MRIs create images based upon tissue density and other tissue characteristics and SPECT scans measure blood perfusion. In SPECT brain scans, radionuclides are injected into the blood and mapped based upon the amount of blood that goes to specific areas of the brain. Injured areas generally have lower demand for blood, uptake less of the radionuclides, and

are detectable in that way. PET scans create images based upon the uptake of radionuclides bound to glucose (sugar) molecules. The PET scan maps the use of glucose by the brain tissue. Active, functional cells use glucose at a higher rate than areas of nonfunctional or dead cells, so damaged areas of the brain uptake less of the radionuclides.⁹

In cases in which imaging studies fail to demonstrate brain injury, demonstrative evidence is even more important. In these cases the demonstrative aids focus more on the behavioral or cognitive changes exhibited by the plaintiff following the incident. The approach is further subdivided into those cases that show some sort of specific head impact, and those that do not. In those cases where a definitive head impact is involved, the location of the impact is emphasized.

In cases where that is not shown, exhibits highlighting the violent back-and-forth or side-to-side (coup/contrecoup) type movements of the head and neck during trauma are used. In our practice, these exhibits tend to

focus on sudden changes in motion resulting in the brain impacting on the inside of the skull. These injuries typically consist of shear injury and/or diffuse axonal injury; shear injury involves axonal shearing at the junctions of white and gray matter.

In cases where there are no physical findings of intracranial hemorrhage or head trauma, it is also very important to thoroughly examine the initial hospital records for behavioral traits that are associated with trauma to the brain sufficient to result in permanent deficit such as "loss of consciousness," references to "concussion," "confusion," or "amnesia." Wherever possible, these notes should be included in concert with demonstrative aids to illustrate the fact that the brain sustained trauma during the event at the heart of your case.

Recuperation for the TBI patient

Demonstrative evidence should be considered to emphasize the plaintiff's (and family's) changes in "quality

issues in litigating continued on page 26



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A value cannot be assigned to peace of mind.

Clients involved in personal injury cases experience several types of trauma. From the initial injury and treatment, through a difficult recovery and on to possible lifelong disability, their losses are overwhelming. They and their families turn to their attorney for guidance and protection.

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of life” following a traumatic brain injury. Testimony or depositions of family, friends, and co-workers are the most effective tools that can be used to emphasize these changes. Experts for insurance companies will testify that your client has no TBI or is a malingerer. The best way to counter this testimony is with compelling “health” witnesses to compare the “before vs. after” of your client. Comparative calendars listing fulfilling activities (accented with pre-accident photographs if available) compared to the plaintiff’s current empty calendars can be arresting visual tools also.

A collage of pre-injury photos should be utilized. Pre- and post-injury videos should be utilized to demonstrate the before and after condition of the plaintiff or decedent. They should be no longer than 5 minutes in length. Finally, enough cannot be said about the importance of “before” and “after” witnesses. These are personal, professional and lay witnesses who can testify to the

changes in the client’s life resulting from the brain injury. These witnesses add a narrative to your argument sometimes, showing that the accident changed the client’s life forever. To orchestrate this part of the case, you’ll need to obtain the complete medical, psychiatric, physical, psychological, vocational, and educational backgrounds of the client.

In our practice representing personal injury clients, we frequently rely on life care planners to provide a comprehensive treatment plan designed to identify the care required to maximize our client’s recovery potential and provide for our client’s personal safety. A life care planner works with the client’s treating physicians and other experts to identify and plan for care and treatment over the patient’s lifetime. Life care planners not only help to communicate the client’s damages to a jury, but add to the level of care by identifying and coordinating the various medical, rehabilitative, supportive care and financial needs of the patient.

Social-environmental factors also influence the effectiveness of

rehabilitation treatments. Caregiver and family support, notably, affect physiological and neurocognitive outcomes independent of TBI severity. These factors also include necessary support for the caregivers themselves.

To guarantee that the jury in your case will be able to observe key witnesses at trial, it may be necessary to videotape their testimonies. Because the mechanism of injury and the resulting damage must be explained to the jury in detail in TBI cases, it’s important that the witness be seen by the jury and that his or her testimony, even on videotape, and this should include the use of demonstrative aids.

Conclusion

Attorneys representing those who suffer from traumatic brain injuries are often presented with the challenge of trying to explain a condition that can’t be seen in the courtroom. It is therefore necessary in all such cases that counsel rely on demonstrative aids to prove the injury. With well-prepared experts and clear and succinct

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demonstrative aids, the jury will be able to grasp the nuances of the changes in your client's life from the injury.

It should also be noted that these are usually not inexpensive cases to take on. Our personal injury practice is limited almost exclusively to clients who have suffered catastrophic injuries – including a wide range of TBI severity. Our many TBI clients who have suffered severe, prolonged and disabling effects of their injuries, have collaborated with lawyers and experts who are familiar with the tools and issues related to this specific type of litigation. When done well, this type of lawsuit can help provide for the individual the support they need for their physical and emotional recovery as they try to piece their lives back together.

Endnotes

¹ Centers for Disease Control and Prevention. (2014). *Report to Congress on Traumatic Brain Injury in the United States: Epidemiology and Rehabilitation*.

National Center for Injury Prevention and Control; Division of Unintentional Injury Prevention. Atlanta, GA.

² Centers for Disease Control and Prevention. (2003). *Report to Congress on Mild Traumatic Brain Injury in the United States: Steps to Prevent a Serious Public Health Problem*. National Center for Injury Prevention and Control. Atlanta, GA. (75% of TBI are categorized as MTBI); Centers for Disease Control and Prevention. (2007). *Head up. Facts for physicians about mild traumatic brain injury (MTBI)*. National Center for Injury Prevention and Control. Atlanta, GA. www.cdc.gov/ncipc/pub-res/tbi_toolkit/physicians/mtbi/mtbi.pdf. (up to 15% of MTBI patients experience persistent, disabling problems).

³ Thornhill, S., *et al.* "Disability in young people and adults one year after head injury: prospective cohort study." *BMJ*, Vol. 320. 17 June. 2000. p. 1632 (emphasis supplied).

⁴ *Id.* at p. 1633.

⁵ Whitnall, L., *et al.* "Disability in young people and adults after head injury: 5-7 year follow up of a

prospective cohort study." *Journal of Neurology, Neurosurgery & Psychiatry*, Vol. 77, pp. 640-645 (2005).

⁶ *Id.*

⁷ *Id.*

⁸ Janet M. Powell, PhD, OT, Joseph V. Ferraro, MD, Sureyya S. Dikmen, PhD, Nancy R. Temkin, PhD, Kathleen R. Bell, MD, "Accuracy of Mild Traumatic Brain Injury Diagnosis." *Arch Phys Med Rehabil* Vol 89, August 2008.

⁹ Flitman, Stephen S., M.D. "Survey of brain imaging techniques with implications for nanomedicine," *Cognitive Neurology Section*, Barrow Neurological Institute. Phoenix, Arizona, USA.

Kent Emison practices at Langdon & Emison, where he has served as lead attorney in traumatic brain injury cases that have resulted in seven- and eight-figure recoveries for his client. He is a Fellow in the International Academy of Trial Lawyers and a member of the AAJ Leaders Forum.



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