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There is no such thing as a “mild” traumatic brain injury

A look at critical evidence issues in brain-injury claims

Brain injuries can be classified into “mild,” “moderate,” and “severe” categories. The Glasgow Coma Scale (GCS) has historically been used as a common indicator for classifying severity based on a person’s level of consciousness on a scale of 3-15 based on verbal, motor, and eye-opening reactions to stimuli. Recent research shows that 75 percent of all traumatic brain injuries (“TBI”) are “mild” in nature. But these so-called “mild” injuries often plague an injured person for life and cause dramatic effects in their work and personal lives. While in most “mild” TBI cases the patient recovers fully, available research indicates that up to 15 percent of patients diagnosed with a “mild” TBI may experience persistent disabling problems. Throughout the evolution of the study of trauma to the brain, doctors and lawyers alike are recognizing how significant any trauma to the brain can be. With the recent publicity of football-related trauma and the increased attention to repetitive concussions, the public at large – and therefore juries – are recognizing how severe even so-called, “mild” brain injuries can be. The purpose of this article is to highlight some of the critical areas of evidence used as well as the potential pitfalls encountered in brain injury trials so that you can maximize the value of your traumatic brain injury case. The reality is that no brain injury is “mild.”

Evaluation of a traumatic brain injury

Plaintiff’s lawyers see a wide spectrum of clients with varying levels of traumatic brain injury, from the concussion to the vegetative-state brain injury. Oftentimes, critical things are overlooked by plaintiff’s lawyers in so-called, mild-moderate TBI cases. The simple reality is that any trauma to the brain, the most vital organ in the human body, is significant.

The most important task at the outset of the case is to properly identify your

client’s injury and develop a game plan to prove up the injury. With an understanding of the critical evidence used in brain-injury trials, and the potential pitfalls along the way, a strategy can be developed that will position your case for success. In any intake of a head-trauma case, it is recommended to use the approach adopted by the Center for Disease Control in assessing the brain injury. First, evaluate:

Any period of observed or self-reported:

- Transient confusion, disorientation, or impaired consciousness;
- Dysfunction of memory around the time of injury; or
- Loss of consciousness lasting less than 30 minutes.

Observed signs of other neurological or neuropsychological dysfunction, such as:

- Seizures acutely following injury to the head;
- Irritability, lethargy, or vomiting following head injury; or
- Headache, dizziness, irritability, fatigue, poor concentration.

Any findings of the above criteria place your client into the category of a “mild” TBI at a minimum. Although more important, the evaluation must delve deeply into your client’s ongoing problems. In the context of the personal-injury plaintiff, for those who end up seeking legal counsel for their ongoing sequelae of the brain injury, many of the initial problems become persistent. Some indications of a serious problem that you should watch out for include: memory problems, problems focusing, emotional issues, personality changes, persistent tinnitus, fatigue, dizziness, headaches, vision problems, loss of organizational skills, problems multi-tasking, lack of motivation, and apathetic behavior.

As part of the evaluation process, it is helpful to obtain the initial hospital treatment records. Such records typically include the EMS report and discharge summary from the initial hospital. Look

for any deficit in the Glasgow Coma Scale (anything below 15), and the extent to which the patient was treated for TBI. Do the documents reflect memory loss or other cognitive dysfunction? If so, these are clear indicators of TBI.

Next, obtain the follow-up treatment records and employment information. Evaluate the extent to which the treatment records confirm diagnosis of “head injury” or at least your client’s complaints of memory loss, for example. Investigate how the incident affected your client’s work. Often times in “mild” TBI cases, a client may have gone back to work, but their performance has suffered as a result. Dig in early and interview witnesses as appropriate.

The next step of initial focus is to evaluate the forces involved in the collision and assess the impact to the brain. Ask yourself: (1) Was there a skull or facial fracture? (2) Was there a scalp laceration? (3) Was there surgical intervention (craniotomy, craniectomy, burr hole, scalp sutures?). Try to determine at an early stage the forces involved in the impact by obtaining police photos, vehicle damage photos, and repair estimates. Use your accident reconstructionist to help you understand the forces and the occupant kinematics your client experienced. Even in admitted-liability cases, it can be extremely helpful to do a full accident reconstruction with animation workup in order to illustrate for the jury what happened to your client for purposes of damages and causation. Often a defendant may admit liability but dispute causation and the nature/extent of your client’s injuries. In a big-force impact, use the reconstruction and animation to your advantage and get the defense experts to admit that the underlying forces are relevant to your client’s future outcome – the more severe the initial impact, the worse the potential outcome. This common-sense approach, even where your client has

See Lucas, Next Page

arguably made a relatively good recovery, has tremendous visual impact with the jurors, who begin to realize, “It’s no wonder the plaintiff has a brain injury; she was hit by that truck at 45 miles per hour!”

Often a TBI that is classically “mild” or “moderate” goes unnoticed to the untrained eye. A thorough assessment of your client’s ongoing problems will illuminate if there are truly any ongoing sequelae of TBI, which may warrant a full TBI workup. This full workup is expensive and time consuming, but is essential if your client has persistent deficits relating to the underlying trauma. For a full TBI checklist, please contact the author.

Assist your client with rehabilitation and therapy

Whether you are dealing with a double craniotomy or a concussion, the most important thing you can do at the outset is to develop a strong game plan for the TBI workup and execute the plan from the very beginning. Typically this involves the hiring of medical experts to evaluate your client as well as to meet and coordinate with any treating doctors involved in the client’s ongoing treatment.

It seems that more often than not, clients with TBI are not provided with the rehabilitation and therapy they need, and are left to their own devices. Part of the initial client game plan should include assessing whether the client is an appropriate candidate for residential treatment in a facility such as Casa Colina, Learning Services, or Centre for Neuro Skills. Some of these facilities will accept the patient on lien given the right situation of liability, insurance, etc. These facilities can provide 24-hour rehabilitation services and also a day-treatment option depending on the severity of the situation. In less severe situations, the client may benefit from weekly counseling, support groups, and publicly available brain-injury rehabilitation courses.

One option which many clients may benefit from is brain-injury courses offered through various community colleges. In Los Angeles, Santa Monica College is a viable option, which offers both for-credit and non-credit classes. Such programs typically focus on cognitive improvement including memory,



3T MRI Corpus Callosum — Black dot shows area of damage.

concentration, and processing speed. Additionally, some colleges offer courses to assist students with more complex activities of daily living, such as handling basic finances and community-living-skills development. These programs are helpful in the litigation context in that they show the plaintiff is actively trying to get better to mitigate damages. Often defense experts will argue the brain-injured plaintiff would get back to baseline if he or she only had some basic rehabilitation and therapy. A diligent course in a rehab program not only takes away this frequently used defense, but also usually results in helpful damages testimony.

In virtually every brain-injury trial, the rehab therapists (speech, occupational, and physical) end up testifying. Depending on the severity of your client’s impairments, and the brain-injury savvy of the therapist, this testimony can be either helpful or hurtful. You can imagine that defense lawyers love to call the physical therapist who treated your brain-injured client for his orthopedic injuries to mention how he had no idea your client even had a brain injury. For this reason, it is a good idea to have an understanding who the therapists involved are and reach out to them before the defense lawyers try to subpoena them.

Diagnostic Imaging – A picture is worth a thousand words

The single most persuasive piece of evidence in a brain-injury trial is often a visual image of the brain damage itself. The problem faced by most mild-moder-

ate level TBI cases is that brain damage typically does not manifest itself on CT scans unless there is a traumatic bleed (subdural/epidural hematoma, etc.). With the use of a specialized MRI, known as the 3.0 Tesla (“3T”) and the correct imaging sequence, known as susceptibility weighted imaging (“SWI”), previously unidentified damage can be seen diagnostically. Most trauma centers treating potentially brain-injured victims will run a CT scan or basic MRI, which does not utilize the full technology available today. In fact, the 3T imaging is only available at a handful of radiology clinics in Southern California. It is critical to ensure the 3T MRI is done appropriately with the correct sequence. You may consult with your treating neurologist to determine his or her preferred sequence.

Once the 3T comes back and a report is generated by the neuroradiologist confirming the diagnosis (i.e. diffuse axonal injury, focal hyper-intensity signaling consistent with trauma), the best use of this imaging is to create a medical illustration for use at mediation/trial. A very effective illustration can be the actual MRI image on the left with an intensified medical illustration on the right that identifies and highlights the blood/brain damage.

In the scenario that the imaging comes back “negative,” this is not a death-knell. In fact, studies have shown that imaging alone is not the best indicator of a brain injury. Imaging must be correlated with clinical evidence of ongoing sequelae of injury (cognitive deficits, emotional

See Lucas, Next Page

problems, etc.). With emerging trends in “mild” TBI, including blast neurotrauma, it is becoming more apparent that the MRI is not the end-all-be-all in terms of diagnosis. With thousands of brain-injured war veterans returning home, the VAs across the country are seeing young men and women with classically moderate-severe deficits, yet the imaging comes up negative for organic damage. The studies in this area go back to the 1970s and provide persuasive proof that just because a patient does not have visible injury on a brain scan does not mean that he or she is not seriously impaired as a result of a brain injury.

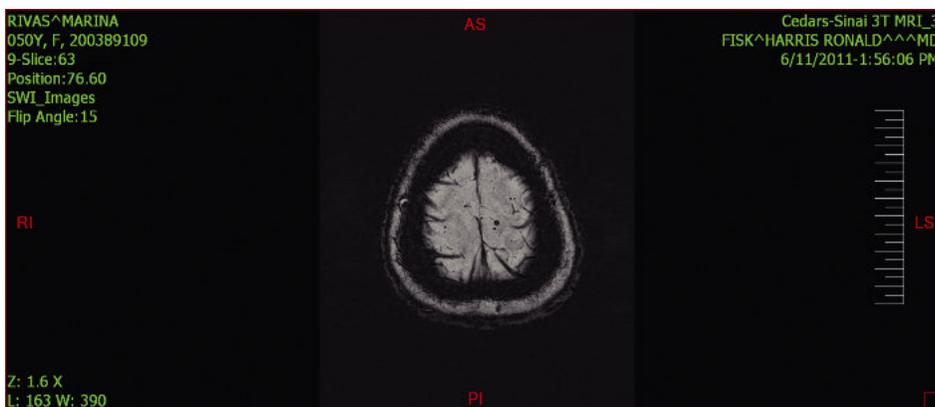
If your case involves a “negative” scan, the best way to combat the defense in this regard is to focus on the clinical evidence of your client’s impairments. Clearly, the treating physicians, therapists, and family members of your client know more about the deficits the plaintiff is facing than the radiologist does.

In a recent brain injury trial, *Rivas v. JB Hunt*, we were able to use evidence of a “tiny” hole in an area of the brain known as the corpus callosum to help explain our client’s severe chronic-pain disorder.

In the *Rivas* case, the client required a walker to ambulate and was essentially non-functioning due to severe chronic pain. However, her Glasgow Coma Score was 15 at the scene and she did not have any physical injuries what would explain her severe pain. TBI research confirmed that the corpus callosum is involved in the transfer of pain signals which we used in trial to explain that even though the physical damage appeared relatively small (less than the size of a pea) this damage was only the “tip of the iceberg” in terms of what actually appears on a scan. This damage in the area that transfers signals back and forth between the left and right brain supported our claim that due to diffuse axonal injury (widespread shearing) Ms. Rivas sustained a brain injury that was the cause of her pain disorder.

Focus on the impact

Whenever possible in a TBI case it is key to focus on the severity of the impact from a biomechanical standpoint. Jurors have a tendency to focus on whether it is a big impact or not, and a good



3T MRI — Black dots show areas of axonal shearing

biomechanist is required to explain the forces your client’s brain endured. The problem in “mild” TBI cases is often that the impact was relatively minor.

This analysis begins with an evaluation of the speeds and forces of impact and the weights of the vehicles/cargo involved. This also includes an appreciation of the rotational forces, if any, as rotational shearing of the brain is one of the most common and problematic forms of traumatic brain injury.

After the accident reconstruction workup has been completed (vehicle inspections, ECM downloads, police and witness depositions) it is important to speak with your medical team about the biomechanics involved. It is good practice to work with the treating doctors, whether it be the neurosurgeon or ER trauma doctor. Often the treating doctors are more receptive to helping your case if they are asked to assist in the preparation of medical illustrations/animations, as opposed to just being subpoenaed to testify in deposition or trial.

In virtually any case worth going to trial, a biomechanist can be utilized to highlight the severity of the impact and the kinematics of precisely what occurred to the plaintiff’s brain. In recent trials we have used specially-designed kinematic animations to depict the plaintiff’s body, the force of impact, and the trauma to the brain. While such endeavors are definitely expensive, they are extraordinarily persuasive to a jury. After polling a recent jury following an eight-figure verdict for a severely brain-injured young

man, the foreman mentioned that the most compelling evidence for her was the animation showing how the brain gets sheared as it bounces around inside the skull. Certain stock animations can be purchased cheaply online, and sometimes are available for free.

How to approach the DME

The defense medical exam for brain injuries seems to be devolving into an often protracted, multi-expert, quest to find malingering. It is a rare occurrence that a reasonable proposal of defense exams is presented, and therefore court intervention is often needed to set the scope. The last thing you want is your client attempting to commit suicide after repeated psych DME’s, right? This stuff happens, trust me.

Clearly, defendants have their one bite at the apple with the medical exam allowed by code. If defense counsel wishes to have a standard neurological exam without leave of court, there is usually not much one can do to stop such an exam. In fact, a course that has routinely worked for defendants is to conduct an exam with their expert which allows you to get their expert report in 30 days. After that, when defendants seek to compel additional examinations, you have the benefit of knowing their neurologist’s opinions. More often than not, the defense hired gun says your client is not injured and doesn’t need any further evaluation. This report can come in handy when arguing against additional examinations. More

See Lucas, Next Page

importantly, the common theme seems to be that no matter what you agree to, the defense will always want more. Set the parameters early, and insist on obtaining a clear list of all the neuropsychometric batteries they request. Determine what is best for your client, whether he or she can do an all-day evaluation, or if two sessions is better. From surveying a number of local neuropsychologists and attorneys on this issue, the standard in the industry seems to be one day of neuropsychological testing. It is worth the good fight to protect your client from unduly burdensome examinations.

Malingering & sub-rosa

As we all know, the standard defense in brain-injury cases is that your client is a fraud. He's a faker, a malingerer, an exaggerator, or, in med-speak, suffers from somatoform disorder. Be prepared from the outset on this issue and use this to your advantage.

Before any medical examinations, caution your client about this issue. No matter how brain injured they are, they must understand the importance of giving their best effort and always being truthful. Tell them from day one that the likelihood is that at some point they are going to be followed and videotaped. The last thing you want is to learn in supplemental disclosures that there is video footage of your brain-injured client giving an eloquent speech on the bow of a yacht to a hundred party-goers for his 30th birthday yelling "I'm on Top of The World" like DiCaprio in Titanic. This also happens, trust me.

When defendants embark on the sub-rosa, get every shred of sub-rosa evidence including the depositions of all investigators, and use it to your advantage. Sub-rosa discovery begins with Form Interrogatory Series 13.0; however, at early stages of litigation when plaintiffs typically serve form interrogatories, defendants most likely have not conducted sub-rosa surveillance. The key is to send out requests for production of documents asking for all documents reflecting any surveillance, including billing statements, reports, and correspondence. *Suezaki v. Superior Court* (1962) 58 Cal.2d 166 allows discovery of sub-rosa information over an objection on the grounds of attorney work product. Please



Ms. Rivas' Nissan impacted by J.B. Hunt truck



Rivas' head struck by grill of J.B. Hunt truck

contact the author for sub-rosa sample discovery and sample motion to compel.

In a recent mild-moderate TBI trial, the defense had conducted 350 hours of surveillance of the plaintiff. The investigator was brought to trial who testified that he could not find anything inconsistent with the plaintiff's claims. This ended up being perhaps the best evidence that the plaintiff was truly as impaired as she claimed.

Effectively cross-examining defense experts

The cross-examination of defense experts at trial begins with obtaining as many concessions as possible in the videotaped depositions, and forcing the experts to solidify their final opinions. While the examination of a defense expert is the proper subject of many legal treatises, for

purposes of this article there are two examples of a recent brain-injury trial that highlight both ends of the spectrum of the defense "expert."

A recent case tried by our firm resulted in an eight-figure verdict for a plaintiff with a "mild-to-moderate" TBI. The defendant retained a neuropsychologist and neurologist who both examined the plaintiff at length. These two witnesses highlight both ends of the spectrum in terms of how a defense expert deals with a cross-exam, and how to effectively use either a concession or an unreasonable refusal to concede against the expert.

On the one hand, the defense neuropsychologist played fair and made appropriate concessions in accordance with the evidence. On the other hand, the defense neurologist remained incorrigible

See Lucas, Next Page

in his opinion that the plaintiff was not injured, created medical nonsense to support his opinion, and ultimately had no credibility before the jury. The trick is knowing how to get what you need from each kind of expert.

In this case, the neuropsychologist report confirmed the severity of plaintiff's ongoing deficits, but blasted the plaintiff as being a malingerer even though she passed five of six malingering measures. The issue really was that her chronic pain disorder and depression — both of which are admittedly somewhat subjective — were hindering her cognitive performance. When it came time to testify under oath, the neuropsychologist backed off the malingering opinion completely and merely said any exaggeration was likely due to somatoform issues related to pain and depression. Under questioning, he was locked into the position that the plaintiff was not faking, malingering, or exaggerating. This neuropsychologist was also ill-prepared to discuss the neuroradiology findings in a recent 3T MRI scan of the brain and parroted the findings documented by plaintiff's expert.

In this particular case, plaintiff had a tiny hole in her corpus callosum, which was arguably clinically insignificant. However, when led down the golden path of concessions, the good doctor admitted how critical the corpus callosum is and that the injury as documented in the 3T was likely the cause of plaintiff's ongoing sequelae. This result highlights the importance of two points of strategy. First, a medical practitioner should never discount your clients' subjective complaints of pain and depression, especially when they pass most of the malingering measures. Second, be prepared to cross-examine the expert with the best medical records that are helpful to your case. Using the 3T MRI to your advantage whenever possible is extremely effective. In trial, the selected video deposition testimony was played in the plaintiff's case-in-chief and this defense expert essentially became a plaintiff expert.

The defense neurologist wrote a DME report stating that the plaintiff needed no further medical care, and no further medical imaging was necessary. After his exam the plaintiff did in fact have the 3T

MRI, which undoubtedly had signs of diffuse axonal injury and other trauma. This physician stuck to his guns and claimed that the brain damage on the MRI was "not that bad" and that the holes in her brain were "tiny." This position became ridiculous at trial in the context of the other experts explaining that any hole in one's brain is not a good thing. Furthermore, without the benefit of the support of the psychologist claim of malingering, the neurologist was forced to concede that he could not dispute plaintiff's subjective claims of cognitive problems, depression, and chronic pain.

Collateral-witness information

As brain injury trials have a tendency to get overly technical on the medical side of the testimony, jurors seem to really focus on the real life information that comes from the family members, friends, and co-workers of the plaintiff. Collateral-witness information is absolutely critical in any brain-injury case. Even more so than the doctors and the imaging, the single most important piece of evidence in a brain-injury trial is usually the key damage witnesses.

Often a "mild" TBI patient will perform reasonably well on neuropsychometric testing but still have complaints of depression, personality change, fatigue, and other complaints that don't necessarily get illuminated in the testing. Information from your client's friends, family, and co-workers is crucial in this context to explain the before and after. The best witness in this context is an uninterested third-party witness who does not have any kind of stake in the litigation. In one recent brain injury trial of a 16-year old with a moderate TBI, a neighbor from the plaintiff's mobile home park was located who testified that the boy would occasionally do yardwork for him. After his accident, he continued to hire the plaintiff to do odd jobs, but found that the boy could not even figure out how to work a garden hose. This testimony was real and, in polling the jury after the verdict, several jurors stated that it was the most persuasive evidence in the case.

At the outset of your case, get a list of damage witnesses and reach out to them. Have your life-care planner interview the

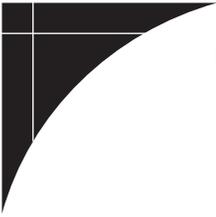
best ones, and share this information with your team of experts so they can rely upon it in forming their opinions that your client has suffered serious and life-changing impairments. Nine times out of ten the defense experts won't have the opportunity to get this valuable collateral information, which you have a leg up on obtaining.

The life-care plan

The question with the "mildly" impaired brain-injured victim becomes, "so what future medical care does he/she really need?" The answer is that a brain-injured victim requires all the necessary medical care that would put him or her back into their shoes before the injury. Even a person with mild deficits that is still working likely relies upon family members for many activities of daily living. These plaintiffs are often referred to as the "walking wounded." They are working, driving, and generally going about their business. But they are doing it in an impaired fashion with much more effort and more reliance on friends and family.

The life-care plan should include the obvious things such as a case manager, therapy, diagnostics, neurology follow up, medications, neuropsychiatry, neuropsychology testing, ongoing attendant care and assistance in the home. If your client is relying on friends and family members for assistance and supervision, these items should be given a focus in the life-care plan based on the average cost for attendant care in the marketplace. Your client's anticipated deterioration over time should also be accounted for in the life-care plan, especially in the context of a pre-disposition for dementia. Research has shown that risk of dementia nearly doubles in TBI victims. Most of the research in this area is focused on moderate-severe TBI; however, there is no question that any TBI only decreases a person's ability to cope with age-related problems. As such, your experts and life-care planner should be prepared to discuss age-related complications and to include certain assistance as either a line item or contingency item in the life-care plan.

See Lucas, Next Page



Conclusion

Insurance companies across the board have been cutting costs, and the big-money payouts seem to be fewer and fewer. In the case of TBI, the trend appears to be that a verdict is required to prove to the carriers that your client is

injured. Obviously there are some exceptions, but by and large, the default is that your client is faking and any money offered will be a pittance in comparison to your client's impairment. As for mild TBI, insurance companies are even more reluctant to appreciate that your client is one of the walking wounded and is likely to

have life-long impairments. For these reasons it is all the more important that TBI cases be worked up properly with an eye for critical focus points should the case go to trial.

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