

# TRAUMATIC BRAIN INJURY CASES

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**Traumatic Brain Injury Cases**  
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**INTRODUCTION**

This paper is intended to discuss the concept of traumatic brain injury within the context of personal injury litigation, including truck and auto collision cases. The focus of my speech will be on those traumatic brain injuries that are not present on radiological imaging and those brain injuries that are not medically categorized as severe in nature. Severe traumatic brain injuries will be well documented in the medical records and the medical providers will be able to provide detailed evidence of injury, impairment, and loss of function. It is not common for there to be much dispute on either side of a lawsuit about the presence and implications of a severe traumatic brain injury. It is those traumatic brain injuries that have been categorized as mild traumatic brain injury (MTBI) where there is room for debate and disagreement about the nature and severity of the injury during the litigation process. Accordingly, my focus will be on mild traumatic brain injuries and the top ten (10) important points to consider when litigating a case with an allegation of a mild traumatic brain injury.

**DEFINITION OF TBI**

Traumatic brain injury (TBI) is a major cause of both death and disability in the United States. The Centers for Disease Control and Prevention (CDC) estimate that 138 people die each day in the United States from injuries that include TBI. Many people that survive with a TBI have residual disabilities that last for the rest of their lives.

A TBI is defined by the CDC as a “bump, blow, or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.” No loss of consciousness is required, but there should be an alteration of consciousness in some regard (such as dazed or confused). In a motor vehicle collision, a TBI is often caused by the forces associated with deceleration of the vehicle from its pre-collision speed to a sudden, abrupt stop. The brain has the consistency of jello and sits encased in the skull with minimal room for movement. The inside of the skull, particularly where the frontal lobe of the brain is located, has rough ridges and is not very smooth. As a motor vehicle collision occurs and the vehicles come to an immediate stop, the brain moves around within the limited space of the skull and may contact those parts of the skull that are rough and can cause injury to the brain that is gelatinous in nature. Additionally, the electrical transmission of information along the pathways of the brain known as axons may be damaged at a cellular level affecting how someone’s brain works and processes the events of daily living. This injury may not be apparent to the injured person or the attending healthcare providers on the day of the motor vehicle wreck. Therefore, it is always important to investigate and determine whether someone has sustained a TBI when there has been motor vehicle collision, particularly at highway speeds or involving a large truck or commercial vehicle. You need to ask the right questions to the right

people and make sure your client gets the appropriate medical care so a timely diagnosis of TBI can be made.

So what symptoms can be associated with TBI? Some of the common symptoms of TBI can be memory problems, word retrieval difficulty, headache, difficulty with processing information, inability to follow through or complete tasks, trouble with reading, impaired ability to concentrate, change in personality, trouble sleeping, frustration, extreme fatigue, volatile temper, greater impulsivity, inability to perform job functions, no motivation, and depression. These symptoms can increase as time goes on due to the person's inability to cope with the impairments related to the TBI. Many marriages can end up in divorce and familial relationships can become strained. TBI patients are at greater risk of future suicide, substance abuse, clinical depression, and unemployment. A person with an acquired TBI due to a motor vehicle collision will be a client that will need your help on many levels and require a large investment of your time, energy, resources, and compassion. Therefore, case investigation selection is vital to the success of your lawsuit. Just because a case can be made, does not mean that it should. If a TBI is not carefully vetted before selection, then your large investment of time, resources, and emotion can be for naught, especially with a competent defense attorney on the other side.

### **#1: THE INITIAL RECORDS MAY BE MISLEADING**

Imagine the scene of a motor vehicle collision that has just occurred. The first responders make contact with the injured person and ask the usual question, "Are you okay?" The knee jerk of any person who can respond will be to say yes. That is when the first evidence is collected regarding the injured person. The ambulance personnel will be assessing the injured person for any injury that is immediately life threatening or needs treatment at a hospital. If a person is talking, there will likely be standard documentation of being alert and oriented. There may also be a notation of no loss of consciousness even though the ambulance personnel were not there to witness the immediate aftermath of the collision. The ambulance crew then will transport their patient to the hospital if deemed necessary and give their reported observations to the ER nurse, so similar documentation will continue. Those people who are not determined to be injured enough to transport to the ER will likely go to their primary care provider within a day or so with typical complaints that are orthopedic in nature and any potential TBI will not be detected or screened for.

In the ER, the focus will be on determining whether the patient has any life threatening injury and needs any medical or surgical intervention. If there is any possibility of head trauma, radiological imaging (typically a CT scan) of a brain will be ordered. A CT is not as sensitive to a TBI as an MRI. A CT will only reveal whether there has been any bleeding in the brain due to trauma. It will also reveal if there are any tumors. It will not reveal if there has been any damage to the brain at a cellular level or whether there have been any injuries to individual axons of the brain. This testing will typically be interpreted as negative meaning no bleeding or tumors of the brain. Mild TBI does not typically show up on conventional radiological imaging such as CT or MRI.

Keep in mind that most hospitals have their MRI scanners set to run a protocol that is not as sensitive to subtle TBI. If your clients have a brain MRI after their injury, the ordering physician needs to specify TBI protocol for the MRI so that more subtle evidence of TBI may be visualized. Additionally, do not take the radiologist's interpretation of a brain MRI as 100 percent accurate. To know for sure about what is there, have a neuro-radiologist look at the MRI of the brain to determine that the TBI protocol was used and that the interpretation of the study was correct. If both the CT and MRI do not show evidence of a TBI, this **does not** rule out that a patient has a TBI. In fact, the literature is replete with references which support this basic proposition. Even the most conservative neurologist will have to grudgingly admit under oath that negative radiological imaging does not mean there is not a TBI. This reality just means that you will have to provide evidence of your TBI through other means. I will discuss what I suggest in that regard below.

In the ER, more than half of the diagnoses of TBI are missed. The focus is on immediate triage of patients with obvious signs of injury or illnesses that need prompt medical or surgical intervention. The most common scoring system used in the ER to describe the level of consciousness following any head injury is the Glasgow Coma Scale (GCS). This scoring system measures eye opening, verbal response, and motor response. You cannot score less than 3. The scores range from 3-15. The goal is to determine which patient needs emergency neurosurgical intervention to either remove blood from the brain or relieve pressure within the brain which is too high and potentially fatal. Factors like drug use, alcohol intoxication, shock, or low blood oxygen could lead to an inaccurate score on the GCS. A GCS of 3-8 is a severe TBI, a GCS of 9-12 is a moderate TBI, and a GCS of 13-15 is a mild TBI. Keep in mind that these classifications are only being made at the time of assessment in the ER and do not foretell how a brain injury can progress or whether it will resolve. Someone can have a GCS of a 3 and make a complete recovery and another person can have a GCS of 15 and die within 24 hours. The GCS is merely a tool to guide emergency treatment decisions and triage patient care. An initial GCS of 13-15 will classify any patient with a TBI as a Mild TBI. This is where that nomenclature comes from rather than any determination about how a brain injury affects a patient in their activities of daily living.

## **#2: NEVER RELY SOLELY ON THE INJURED PERSON FOR A TBI DETERMINATION**

It is human nature to want to be well and to think that everything is okay. People do not want to have a lifelong disabling injury and will do their best to initially deny that something is wrong with them. Most of my TBI clients did not realize initially that they had suffered a brain injury that would change their lives forever. Most deny that they have lost consciousness even when there are witnesses who confirm that such did occur. If there are no witnesses, do not be surprised if your client claims no memory of any loss of consciousness. Some do not even remember an alteration of consciousness in some regard, but some do. Therefore, it is important to determine what the injured person remembers and when. In order to do so, you need to ask the person what is the last thing that they remember before the incident. Memory loss of events before the

incident is known as retrograde amnesia. You also need to inquire about what is the first thing that the person remembers following the collision. Memory loss after the event that caused the brain injury is known as anterograde amnesia. If there is neither retrograde or anterograde amnesia present, then you need to question whether this is a case to pursue as a plaintiff and defense counsel may use this as evidence of any injury being minor in nature. Beware that people can fill in events with what they think happened and actually have retrograde or anterograde amnesia. Neuropsychological testing with a competent examiner can help determine more about whether amnesia is or is not present in some fashion.

In order to obtain an accurate assessment of whether a person is suffering from any TBI symptoms, it is best to ask family members or close friends outside of the presence of the injured person. You want to give that person the ability to speak candidly without fear of hurting the feelings of the injured person. I once represented a junior high teacher who had a TBI and thought she was struggling a bit at work, but otherwise, was fine. Her family reported that she was a completely different person who struggled with even basic tasks and could not do her own lesson plans anymore. She no longer knew the names of her students and found teaching to be frustrating and not a rewarding experience. She ultimately had to leave teaching and tried a stint as a salesperson at a small retail chain. She could not even remember her employee number to ring up sales. Her TBI, which she did not want to acknowledge, was readily discussed and described by her family members and friends. You must ask the people closest to the injured person to know how they have changed and to determine what symptoms there are.

### **#3: THE COMPLETE MEDICAL AND PSYCHIATRIC HISTORY OF A TBI PLAINTIFF NEEDS INVESTIGATION**

The potential symptoms that an MTBI Plaintiff can suffer from are varied and can be non-specific in nature. In short, there are many medical and psychiatric conditions that can cause some of the same symptoms. Therefore, you need to completely investigate your potential client's past medical and psychiatric history. You want to do this exercise so you do not get any nasty surprises during litigation and so you know what the complete picture is. Do not rely solely on your client's recitation of which healthcare providers have been seen. You need to obtain your client's pharmacy records and insurance records so you can be sure that you are not missing a critical record. Always look at all records of primary care providers without exception. A thorough defense attorney will be conducting the same exercise, if allowed by the Court, so you should do it first. I have been shocked and surprised by some of the information learned, which ultimately led to the declining of the case. This is the best way to authenticate the information given to you by the client and to learn whether someone is truthful. It is better to be surprised before suit, then in the middle of a lawsuit.

#### **#4: UNRESOLVED PRIOR TBI OR PTSD AT TIME OF INJURY CAN BE A CASE KILLER**

Since the symptoms of MTBI are varied and wide ranging, an injured person may have had medical treatment for a similar symptom in the past. This situation is to be expected and can be readily explained as long as the symptoms had resolved before the incident that caused the current MTBI. If a person has had a prior TBI and the symptoms had resolved completely or did not prohibit the person from engaging in normal activities, then likely it should not be problematic for your case development. A problem can arise when a person who suffers an MTBI is undergoing treatment at the same time for prior TBI or for Post-Traumatic Stress Disorder (PTSD). PTSD is a serious, potentially disabling condition that can occur in people who have experienced or witnessed a traumatic event. The symptoms of PTSD can overlap with symptoms of MTBI which can make it difficult to differentiate which symptom comes from which condition. Neuropsychological testing can help illuminate this issue when it occurs in conjunction with an MTBI. The problem is when a person is suffering from either a TBI or PTSD at the time of a motor vehicle collision and is undergoing treatment that is still ongoing at the time of the collision. Any MTBI acquired as a result of the motor vehicle will be difficult to determine and will be make it hard to apportion what was pre-existing versus solely caused to the wreck. This same problem can occur with a person who has pre-existing severe psychiatric problems before an acquired MTBI. Competent experts can have trouble segregating which problems were caused by which conditions. A confusing causation picture is not the way to convince a jury that a defendant caused the plaintiff's injuries. Complexity favors a defense verdict.

#### **#5: FACT WITNESSES PROVIDE THE BEST EVIDENCE OF INJURY**

As everyone is aware, people are inherently skeptical of people who are suing others and claim personal injuries of any type. This situation is especially true when plaintiffs describe their own injuries, especially if it involves a traumatic brain injury. Many people who have an acquired MTBI do not appear dramatically injured when having brief or casual contact with others. It usually takes time and knowledge of that person's personality traits to understand the nature of the brain injury and how such injury has affected their life. Therefore, it is best to present someone with an MTBI through the eyes and experiences of those who know them and interact with them on a regular basis. These people can include spouses, family members, friends, supervisors, coworkers, and ministers. These people can tell the story of a person before their brain injury and who that person is post brain injury. They can tell stories that capture the essence of the injured person's character so that the losses can be more apparent and readily understood by others. If the fact witness is not related to the injured person, that individual will likely have more credibility with others. Fact witnesses paint the real picture of a brain injury in a way that is compelling and gives real life examples of what truly has been lost.

Of course, not every fact witness feels comfortable speaking about others or knows what to say. Some people are just naturally introverted or speak with very few words. I have found a technique that I use when interviewing fact witnesses that allows them to open up and also helps to focus their thoughts if they need to give a deposition in the future. I ask them to give me 5 single word adjectives that describe the injured person before the acquired brain injury and 5 single word adjectives that describe the person post brain injury. Then, for each adjective, I ask them to provide me with a real life story that they remember that illustrates why they chose that adjective. This exercise has been uniformly successful and provides a wealth of useful information. It can also help you garner the most knowledge that is possible from each fact witness that you meet which can help you build your case. You will likely have to meet and interview many people before you decide which 3-5 witnesses can provide you with the vignettes that you need to tell the brain injured person's story.

## **#6: IT IS ALL ABOUT FUNCTIONALITY**

When evaluating damages in a traumatic brain injury case, one needs to focus on the functionality of the injured person both before and after the event leading to the MTBI. This is particularly important when looking at the past medical history of the injured person. There may have been a past history of TBI, head injury, stroke, untreated hypertension, depression, sleep apnea, etc. What you need to focus on is how the injured person was able to function professionally and socially before the motor vehicle collision at issue. If the person was working with glowing evaluations from a supervisor and socializing well with others while easily performing the activities of daily living, then a strong argument can be made that any pre-morbid condition was either resolved or not affecting the quality of life of the injured person. If the injured person was having difficulty at work before the brain injury, it becomes more challenging to isolate the damages to being caused by a brain injury acquired in a motor vehicle collision. Interviewing fact witnesses as discussed above will help you ascertain what level of functionality was real prior to the person's brain injury. This is an area where defense lawyers should spend a lot of time garnering information so that the damages can potentially be minimized or made to look overstated by the plaintiff. Whether you represent the plaintiff or the defendant, you will want to spend a lot of time focusing on the pre incident functionality of the plaintiff.

It is also important to be able to identify and describe any loss of functionality that the plaintiff has suffered as a result of an acquired brain injury. You will need to know how and why any job functions cannot be accomplished. You need to find out what typical daily routines or hobbies can no longer be done and why. On the other hand, if adaptive techniques can be utilized to allow for work activities to continue then you need to know that as well. You want to know what limitations are present and cannot be changed as well as what accommodations can be made to allow life to continue as it did before the brain injury. If you will focus on the issue of functionality of the injured person, then you can more accurately assess the real damages that have or have not resulted from the brain injury.

## **#7: THE INJURY HAPPENS TO THE BRAIN IT HAPPENS TO**

When someone sustains a mild traumatic brain injury in a motor vehicle, it is important to know something about the brain that was injured. You will want to know what the baseline was for the person who was injured. One way to determine the baseline is to look for evidence of standardized assessments that were done to assess the intelligence or strengths of the person before the injury. A good way to look for this information is to obtain educational records which contain the standardized testing that was done on most people during their schooling. IQ will likely have been measured and various subjects will have been tested. For example, you may be able to show that before the injury that the person had a strong aptitude for math and that post injury simple math has become a problem. Grades are not usually indicative of how intelligent someone is because there are many variables that account for good or bad grades. Very high grades before the incident, though, can be a positive to use if you represent the plaintiff who now has significant cognitive difficulties. You will want to make sure to obtain as many educational records as you can from before the injury as well as any post injury as well. These records also help neuropsychologists when conducting testing and to determine the nature and extent of any cognitive deficits.

If the injured person has suffered a prior TBI, then you need to be aware that any later TBI sustained can be more damaging and have more long term effects. That is why you will want to know what the baseline level of functioning was for a person before the motor vehicle collision at issue.

Beware of any long term untreated sleep apnea. This situation leads to someone who is getting low oxygenation every night when they are asleep. The literature supports that long term untreated sleep apnea can cause many of the identical symptoms of MTBI. This may be an issue for the truck driver that was a contributing factor in the collision. It can, however, likewise explain some of the symptoms that a plaintiff with MTBI has rather than the motor vehicle collision.

## **#8: TIME WILL REVEAL THE EXTENT OF INJURY. DO NOT BE HASTY.**

When someone sustains an MTBI in a motor vehicle collision, the true extent of that injury is frequently not known for many months. When the injury occurs, there is an inflammatory response and a chemical release that typically results in a gradual cascade of pathology. According to the literature, the majority of persons who sustain MTBI will return to baseline function. For this reason, it is imperative to wait and see whether the injured person's symptoms will subside, increase, or remain the same with the passage of time. At a minimum, you need to wait 6-12 months to see whether an MTBI will resolve. I have personally seen clients with significant disability return to baseline after 3-4 months. I have also seen those clients with MTBI whose lives are forever changed and their symptoms do not resolve and may even worsen. If a lawsuit is filed immediately, you will not know which path your client with MTBI will follow. Furthermore, neuropsychological testing done too early may not reveal the true extent of any disability. Additionally, be prepared to do additional neuropsychological testing

once a year has passed. Your client may also be prescribed or need to participate in cognitive rehabilitation. You will want the cognitive rehabilitation to be complete before you can assess the condition of the person with MTBI. It may be that adaptive techniques or strategies were learned that lessened the impact of MTBI. It could also be that the cognitive exercises done actually helped and the injury is no longer readily identifiable. Finally, the cognitive rehabilitation may not change the devastating effects of the MTBI. Either way, you need to know what the result will be or the defense will likely argue that the plaintiff failed to mitigate their damages with cognitive rehabilitation.

### **#9: LOOK FOR OTHER SIGNS OF TBI- EYES, EARS, NOSE, ENDOCRINE**

With MTBI, other parts of the body can manifest injury due to trauma to the brain. You will want to pay attention to all complaints of the injured person. If there is a complaint of headache that persists after head trauma and other neurological causes have been ruled out, the injured person should be evaluated by a neuro-ophthalmologist to determine if there are any visual abnormalities due to head injury. Some of these visual problems can cause headache, dizziness, and nausea. There may be visual therapies that are available that can remedy the patient's complaints.

Also, pay attention to complaints of loss of smell or taste as these symptoms can correlate with a head injury from a motor vehicle collision. People may also complain of impaired hearing or unrelenting ringing in their ears. There may be complaints of being unstable with balance or coordination issues. The injured person will need to see an otolaryngologist for any symptoms involving impaired taste, smell, balance, coordination, or hearing. That physician may be able to connect those symptoms directly to the MTBI sustained in the motor vehicle collision.

MTBI can also have an effect on the body's hormones and the endocrine system. The pituitary gland is particularly vulnerable to injury with injury to the brain. After an MTBI has been sustained in a motor vehicle collision, it is a good idea for the injured person to have the following tests ordered by their primary care physician or whoever is caring for their brain injury: TSH, FreeT4, Morning Cortisol, Serum prolactin, IGF-1 (if less than 175 should be referred to Endocrinologist for further testing), total serum testosterone for males, and menstrual history or 17 beta estradiol for women. Hormonal abnormalities that are uncovered through laboratory testing may be further support and confirmation of the presence of MTBI.

### **#10: MILD TBI DOES NOT MEAN MILD INJURY**

The terminology of Mild Traumatic Brain Injury can be misleading to the average person. To some people, this term implies that the brain injury does not have any serious consequences or is not disabling. Nothing could be further from the truth. For many people, the consequences of an MTBI are life changing and permanent in nature. The public is becoming more aware of the pathology associated with MTBI with the media highlighting the lives of those who have brain injuries sustained from blasts from being near bombs exploding in the war or football players who have sustained

numerous hits to the head who end up with chronic traumatic encephalopathy (CTE) in the later years which causes dementia and early morbidity and mortality.

As discussed earlier in the paper, the term Mild Traumatic Brain Injury should be used when using the Glasgow Coma Scale to assess and triage those brain injuries requiring emergency medical or surgical intervention. It is not a term that one needs to embrace if representing the injured person. It is a traumatic brain injury with long term consequences for that person. Each brain is unique and each person's response to a traumatic brain injury will be unique.

An excellent journal article that describes the sequelae of a traumatic brain injury is one written by Brent Masel and Douglas DeWitt entitled, "Traumatic Brain Injury: A Disease Process, Not an Event, JOURNAL OF NEUROTRAUMA 27:1529-1540 (August 2010). The article discusses all of the disease processes and conditions that are associated with traumatic brain injury and the chronic disability that can result from traumatic brain injury. It is important to realize that a traumatic brain injury acquired from a motor vehicle collision may be an injury that starts a progression of disability and disease that may be lifelong in nature.