APIL NW Regional Meeting
14.3.19
Exchange Chambers Liverpool.

Minutes of meeting

Attendance – see attached attendance list.
Guest Speakers – power point presentations provided.

Introductions by Carol Hopwood

Damian Bradley S&G – EC update – see attached PP

Catherine Edwards – BI Secretary.

Dr Ivan Pitman – Consultant Clinical Psychologist "The Frontal Lobe Paradox" (Power point included)

Key points to be considered in conjunction with power point presentation.

- Employed by BIRT (Liverpool) but with 15 centres, 1000 staff across England Ireland and Wales
- Working with families for the last 20 years. Lot of time spent in secure units with people who historically would be described as having mental health issues but often they have suffered a brain injury that had been forgotten about or not diagnosed.
- His job is to encourage the growth of dendrites.
- Grey matter is still developing to mid-20s so brain development can be damaged by intervening trauma
- Nurture v Nature and the impact it can have on the organic structure of the brain is significant. MRi of Romanian orphans shows the stark differences..
- Ensure a full history of any brain injury/illness etc is taken
- Understanding when the pathway between the limbic structure (slow) and the Prefrontal Cortex is broken and how that impacts on behaviour. He will often see limbic driven behaviours and when the prefrontal cortex (the brakes) don't work properly or at all then that has a significant impact on behaviour. When calm and settled the pre frontal brakes may work and behaviour is less challenging but people with this disconnect are easily agitated and angered and they simply cannot stop their behaviours. The frontal lobe paradox. You know something is wrong but you cannot stop yourself. Person can behave very differently in a calm office environment compared to "real life" situations and this is relevant in the context of office based assessments and testing.
- Key risk factors for brain injury – age (toddlers, teens and retired), gender (male) urban location and social deprivation.
- By 2020 – 10 million people worldwide will be affected by brain injury
- TBI is the biggest cause of death and disability in the world.
- Teenagers growing, becoming brazen, and greater risk taking as they leave "the nest"
- 12% of general pop have suffered a head injury
- In prison population more like 50%
    - 73% suffered BI before first offence
    - 42% under 18 when commit first office
    - 43% have been in prison more than 5 times.
    - 80% using drugs and/or alcohol at time of arrest
    - 32% drinking more than 20 units of alcohol per day

- IF have a TBI everything gets harder. Anxiety, depression, disinhibition, aggression, memory and executive functioning. The prison service does not ask about brain injury enough. The right questions are not asked. Many brain injured prisoners are wrongly classified/labelled because of the behaviours they exhibit rather than helped and rehabilitated.

- If a client has a TBI with frontal lobe paradox they are statistically more likely to offend and end up in prison
- Behaviours
    - Miss appointments
    - Talking about same things all the time
    - Inappropriate person comments
    - Never get around to doing things
    - Are the above behaviours or are they as a result of the brain injury they have?
    - IF BI they will respond to neurorehabilitation
- Prison service is trying to do much better screening to identify those with brain injuries and to use the prison service as a rehabilitation unit. Train the prison officers, know which questions to ask.

Floor open for questions.

Gerard Martin QC – Exchange Chambers – Brain Injury and Dementia

- Nordstrom Document 2018 – GM can be asked for a copy of this paper
- Ask the expert about this risk
- General population over 65 years have 5% chance of developing dementia
- In clients with TBI over age 45, there is a four times greater likelihood of developing dementia. The type of injury is relevant. So mild less likely etc
- More likely with severe injuries
- Swedish study using their national database 3 cohorts. BI with controls, dementia with controls and sibling pairs one of who had a BI
- Association between TBI and dementia stronger where dementia occurred in the first year but risk remains significant for 30 years
- Lower risk with single mild TBI
- The paper is subject to some qualification because they were not involved in the initial diagnosis of the tbi or the dementia diagnosis
- Flemiger et al in 2003 – risk of dementia doubled in men but not women after a TBI
- Guo 2000 fourfold increase
- The papers confirms a “clear association” of tbi and a risk of being diagnosed with dementia in later life
- Be careful to establish what type of dementia we are dealing with and then the operative causes. Different types can overlap with each other and cause of dementia is difficult.
- Bailey v MOD – cumulative cause argument and compensable in full?
- Consider competing causes for dementia – pre morbid cognitive function, educational level, alcohol abuse, psychiatric condition, vascular risks and other injuries
- Plead provisional damages – requires a serious deterioration. Could be a massive increase in the level of care and support needed, could impact on residual earnings and accommodation.
- Could damage the case – reduced life expectancy due to dementia. Some are aggressive, some are less so
- May reduce the need for accommodation
- Weigh up whether to raise the risk of dementia at all to the value of the case.
- If client aged below say late 60s ask your neuropsychiatrist to comment on the risk of dementia and refer to the Nordstrom paper.

Additional Practice Points

- Ask Deputy about co habitation agreement - should the deputy costs be included within the Deputy witness statement on their costs
- Staff CC v SRK 2016 EWCOP 27 Charles J – case where case manager must tell the local authority if C is refusing to comply with DOLS. Local auth often do nothing so the Deputy is left to do this. An application should be made for a welfare order by the Deputy to the COP so that DOLs can be enforced.

- Changes to the DOLS system. P v West Cheshire. DOLS increased from 13k PA to 200K PA. There is a draft bill (Mental Capacity (Amendment) bill 2018 – but it departs from the Law Commission proposals. Due to be replaced by Liberty Protection safeguards. LPS burden will be passed to the NHS, care homes or private providers whose job it will be to assess whether the care arrangements in place amount to a DOL. Acid test "is he free to leave" if this is now the responsibility of private providers it will create conflict. All of this carries costs implications for the management of our clients, case managers and deputies. Check whether they should be in your Deputy witness statements
- The Mental Health Act is changing. Interim report of the review into the reform of the act is on line. One of the aims is to rectify the increase in the number of people are being sectioned.
- Settlement values and the person who lacks capacity
    - UN Convention on the rights of persons with disabilities article 3 - suggests that C has a right to know the detail of his settlement
    - EXB v FDZ 2018 EWHC 3456 – Foskett J – C did not have capacity to make the decision in his best interests whether he should be told, that it was not in his interests to that he should be told. The Deputy would have to make an application without notice to the COP if he became aware that someone should know. Deputy costs would be increased for this
- Risk of having Children
    - Women with SBI, disinhibited sexually, unreliable contraceptive. It's not a risk it's a probability. Include costings in SOL. 200 - 300k? would all need to be supported by evidence from family, case manager, GP etc
- Loughlin v Singh
    - Where the care and case management services in an **important respect fell significantly** below the standard that could have been expected and 20% reduction

Floor open to questions

Thanks given to both speakers and a summary given by Damian Bradley