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Gerard is a renowned silk who specialises in brain injury and spinal injury cases for adults and children. He also has a wealth of experience dealing with claims for amputees, pain and somatoform disorders. His career has developed both at the junior bar and in silk, where he has been instructed almost exclusively by those acting for claimants (including those employed in the military) save for certain occasions when insurance companies have sought his assistance.

The majority of his work in silk has been for clients with severe brain injuries, resulting as the consequence of accidents or by way of clinical negligence. Through his vast experience he knows that each case of severe brain injury is unique and with this in mind he believes it unwise to generalise about outcomes, and that much depends upon the individual and the support they receive. Practising in this sphere has meant that the experts on both sides of the litigation divide are known to him, as are the centres of excellence for rehabilitation of the brain injured.

Brain Injury and Dementia and Brain Injury Update 2019

Gerard Martin QC

Recent paper on TBI and Dementia

Nordstrom 2018 published by Plos Medicine (copy available via GM)

The general population over the age of 65 years have a 5% risk of dementia.

In those with TBI over 45 yrs of age, there is an increased risk of dementia, the increase was four times that in the population at large. However it pays to read the paper itself as it requires qualification.

The Nordstrom paper

Nordstrom A, Nordstrom P (2018) PL o S, 15(1).

The paper is the most recent to consider the connection between TBI and dementia – whether there is such a risk, how long the risk remains present over time, whether it is similar for different types of dementia and whether it is influenced by family background.

Methodology.

- All individuals aged over 50 yrs in Sweden were considered for inclusion using data bases from 1964 to 2012.
- In the first cohort individuals diagnosed with TBI were matched with controls not so diagnosed, the number studied was 164,334.
- A second cohort consisted of individuals diagnosed with dementia during follow up matched up with controls, 136,233 in number.
- A third cohort consisted of sibling pairs numbering 46,970, one of each pair with a TBI.

Findings

- During an average follow up period of 15 years, 21,963 individuals were diagnosed with dementia.
- The association between TBI and dementia was strongest when dementia occurred in the first year – but the risk was found to remain significant for more than 30 years.
- Single mild TBI showed a weaker association with dementia than a severe TBI.
- TBI was also associated with an increased rick in sibling pairs with discordant TBI status.

Continued

- The authors of the study warn because they were not involved in the design of the observational studies to conclude dementia or not, they can draw no causal inferences.
- With the above warning, the conclusion was that the risk of dementia decreased over time but was still present 30 years after trauma, the association was stronger for more severe TBIs and multiple TBIs, and it persisted after adjustment for familial factors.

Earlier studies

- Fleminger et al in 2003 Journal of Neurology, Neurosurgery and Psychiatry suggested following meta-analysis that the risk of Alzeimers disease is doubled in men (but not in women) after a TBI resulting in loss of consciousness.
- Guo et al in 2000 Neurology suggested in the retrospective MIRAGE study a fourfold increase in the risk of AD associated with TBI resulting in a loss of consciousness.
- Li et al in 2016 Journal of Neurology suggested the risk of young onset dementia (below the age of 60yrs) after TBI was low for AD but strongly related to non-AD dementia.

What then were the paper's conclusions

- Given the large numbers involved in the study and the lengthy follow up, in some cases up to 50 years, the authors state a "clear association" was observed between previous TBI and the risk of being diagnosed with dementia in later life. The paper must be seen as having a significant impact upon the debate given its sample size and length of study, as such it is a significant step forward in the recognition of a link between TBI and dementia.
- To establish the presence of a causal link in the individual case will have to be case specific.

Continued

- Data from the present study the authors state shows a clear “dose-response” relationship.
- The risk of a dementia diagnosis was almost doubled in siblings with TBI than with their non TBI counterpart so challenging counter-arguments that the environment – genetics, nurture/nature may have been causally responsible.
- Overall the results may support a causal connection between TBI and the risks of different types of dementia. “ However given the observational study design, we cannot exclude the possibility that other factors explain the observed associations.”

What is dementia?

- Different types – Alzheimers, Fronto-temporal, Lewy Body, Parkinsons related, MS related, vascular dementia.

- Care therefore must be taken to establish firstly the type of dementia suffered and then the operative causes, which can be multi-factoral or exclusive. A complicating factor is that different forms of dementia overlap with each other making attribution and cause of symptoms difficult.

- If multi-factoral and attribution to each cause cannot be quantified – could Bailey v MoD case be used to argue accident related and fully compensable?

Possible confounders

- Premorbid cognitive function
- Educational level
- Alcohol abuse
- Psychiatric condition
- Vascular risk factors
- Other injuries

Provisional damages

- The risk of dementia is a qualifying risk- it would be a “serious deterioration” in the physical and or mental heath of the Claimant.
- The need for care would change both quantitively in number of hours and possibly in quality in style of care delivery changing from social to nursing.
- It would impact on any residual earnings.
- The same might apply re the accommodation claim where residential care was needed to manage the dementia.

Complex medico legal assessment of the impact

- The onset of dementia may increase the quantum of the claim re care and earnings but this has to be counter-balanced by –
- A reduced life expectancy – assessment is multifactorial and case specific depending on the type of dementia, rates of deterioration vary.
- A reduced need for accommodation if client needs residential care
- A reduced need for other future losses – services, aids and equipment, holidays, deputy costs.

Do you raise the risk of dementia at all?

- Given the Nordstrom paper the risk of dementia following TBI and its consequences for the Claimant, my view is the risk must be recorded as having been considered by the legal team.

- It is conceivable that the adverse impact on the main action may outweigh the benefit to the Claimant of raising the issue!

My conclusion

- As a very general observation, for someone outside the usual onset of dementia – lets say aged below the late sixties, suffering a severe or multiple brain injuries then I would ask for the advice of a neuropsychiatrist about the increased risk of dementia and refer him to the Nordstrom paper. You will be seeking such a report on capacity in any event from the same discipline– so it will not be at significant extra cost.
- The PMH of the client is going to be very relevant, look for other high risk factors for dementia.

Practice points – Cohabitation

- Client acting with a deputy wants to enter into a relationship he or she hopes to be of longstanding duration.
- The advice of deputy should be sought on whether to enter into a cohabitation agreement. Not binding on a divorce court but significant evidence to be considered by that court.
- Does he or she have the issue specific capacity to enter such agreement – if not – should application be made. Certainly one very reputable firm of deputies claim the cost of the above in the deputy's costs statement.

Care packages – is he free to leave?

- Staffordshire County Council v SRK 2016 EWCOP 27, Charles J.
- Protected party is bought a house and a 24/7 care package, package involves a best interest decision that he is not free to leave, he does not consent to the same. Usual procedure that the case manager informs the local authority who ought to inform/ make application to the Court of Protection. Regularly nothing happens and it is left to the deputy to regularize the position.
- Court decision is that application must be made to C of P for a welfare order authorizing his de[privation of liberty.

Changes to the DOLS system

- Since the Supreme Court decision in P v West Cheshire in 2014 which gave a broad interpretation to deprivation of liberty – Baroness Hale's acid test – "are you free to leave"?
- Dols referrals have gone up from 13,000 pa to 200,000pa. The system is not fit for purpose. The Law Commission report of 2017 recommended urgent changes and proposed a draft bill.
- The Government have launched a draft bill in the House of Lords in July 2018 – The Mental Capacity (Amendment) Bill 2018 which departs significantly from the Law Commission proposals.

LPS

- Dols to be replaced by Liberty Protection Safeguards, the role of the local authority is to be replaced by placing the burden on the NHS trusts, care homes and private providers of care who will have to assess,
- 1) whether the care arrangements amount to a deprivation of liberty, 2) an LPS is not excluded by the MHA, 3) the person lacks capacity for the relevant decision and 4) the care arrangements are necessary and proportionate.
- The above will carry cost implications for the management of our clients, for case managers and deputies.

LPS continued

- So far there have been more than 100 amendments tabled to the Bill.
- The expectation is that it will receive Royal Assent and be in force by the end of this year.
- There is a saving to local authorities but the proposals have been widely criticized as lacking funding, it under estimates the training required to implement and creates obvious conflicts of interest between the commercial interest of the care provider and their duty as LPS assessors.

The draft bill and mental capacity

- The best interests checklist in section 4 of the MCA is amended to require greater weight to be given to ascertainable wishes and feelings of the person concerned. The decision maker must first of all ascertain “so far as is reasonably practicable” the wishes and feelings of the person concerned and then give those wishes “particular weight” in coming to the best interest decision.
- May make the presumption of capacity harder to overturn in borderline cases?

The reform of the Mental Health Act 1983

- The interim report of the review into reform of the Act is available on the internet, the report published in October 2018.
- The aim is to rectify the worrying increase in first time use of sectioning under the MHA.
- To give greater support to keeping clients in the community for treatment if possible
- To increasing their support in hospital during the sectioning process.

Should he be told the settlement value?

- United Nations Convention on the Rights of Persons with Disabilities – article 3 suggests that a person in C's position – brain injured should be informed of the detail of his settlement.
- In EXB v FDZ 2018 EWHC 3456, Foskett J sitting in the QBD and C of P declared on the application of the deputy C did not have the capacity to make the decision in his best interest whether he should be told, that it was not in his best interest he should be told, and that deputy was permitted to make an urgent with out notice application of the C of P if he became aware someone required that information. ADDs to deputy costs.

Other recent issues in my practice – risk of having children

- At the present time this risk is usually compensated at a settlement meeting by a contingency lump sum.
- Scott Baker J decision many years ago, not appropriate for multiplier/multiplicand approach.
- But this may seriously under compensate the client. The risk is not a risk but a probability.
- SBI female client – disinhibited generally and sexually, cognitive abilities reduced, may lack capacity, may be highly vulnerable and inconsistent in her use of contraceptives.

Continued risk of children

- In the above circumstances the risk is not a possibility but a probability.
- Sensible presentation would be that within 3/5 years of the trial the Claimant on the balance of probability will have a child.
- If that occurs, she will need the extra costs of supporting her through childbirth and then in caring for her child until the child is independent.
- That cost will significantly exceed a conventional lump sum contingency award.

Evidence to support the multiplier/multiplicand approach.

- Family statements
- Case manager statement re deficits, vulnerability, inclination, lack of contraception.
- Support from experts – neuropsychiatry, neuropsychology – executive problems/ memory/ mood disorders.
- Costings from care expert – doula/nanny/ extra support worker hours.

When does a Loughlin v Singh risk arise

- Kenneth Parker J judgment stated that the care and case management services "did in an important respect fall significantly below the standard of care that could have been expected" and therefore had to be marked, a discount of 20% off the fees claimed was ordered.
- In that case the sleep disorder had gone unaddressed for about three years.
- The danger is that Defence practitioners misinterpret the judgment and argue for a deduction wherever they find issues to criticize.

Loughlin v Singh

- Thus in one of my recent cases the Defence tried to argue by reference to a number of insignificant individual shortcomings in the case management provided that cumulatively that amounted to a Loughlin v Singh situation where a discount ought to apply. This was on our application for an interim payment – roundly rejected by the Master as inappropriate and unlikely to succeed at trial.

The End

- Questions or comments?