‘mTBI litigation in light of the QBD decisions in *Long & Stansfield* – mTBI is not necessarily ‘mild’ when there are overlapping AV, pain or psychological injuries’

Introduction

1. The High Court handed down two judgments this year on injury claims arising out of concussive head injuries following objectively modest trauma. In each case, the claimant reported a cluster of enduring subjective enduring physical, cognitive, behavioural and psychological symptoms that prevented him from functioning optimally in his work and home lives.

2. In each case, whilst the defendant was prepared to admit to some objective short lived soft tissue and minor psychological injury, it denied that there was any substantive organic or compensable enduring psychological injury.

3. Both judgments, which exceed 100 pages, acknowledged that the medicine underpinning these cases was complex and could only be understood properly by appreciating the nuances of the overlapping clinical disciplines. In doing so, the Court in each case acknowledged what is widely reflected in the clinical literature over the last three years, which is that a significant cohort of patients suffering symptoms following a concussive head injury have historically been disenfranchised by the medical profession because the medicine underpinning their symptoms has not been properly understood. Inexorably, as a result they have similarly been disenfranchised from the legal process too.

Mechanism of the injury

4. In the case of *Long v. Elegant Resorts Limited* [2021] EWHC 1330(QB) heard by his Honour Judge Pearce QC sitting as a judge of the High Court, Mr Long (L) struck his forehead when attempting to walk through a doorway with a low door lintel that he did not see. He was a 43-year-old Head of IT employed by the defendant at the time of the accident, and aged 47 at trial.

5. In the case of *Stansfield v. BBC* [2021] EWHC 2638 (QB), heard by Mrs Justice Yip, Mr Stansfield adopted the role of a crash test dummy for the BBC in two forward facing and two rearward facing simulated crashes into a metal post at speeds of between 8 and 11 mph see: https://www.youtube.com/watch?v=mT4s9_3V1UE. Mr Stansfield (S) was a 42-year-old television presenter at the time of the accident, subcontracting his services to the BBC, and aged 50 at trial.

6. There was agreed expert engineering evidence that the biomechanical forces of each individual crash test had the potential to expose S’s brain to potentially damaging forces.

Purpose of the paper

7. It is observed that whilst both mechanisms are outwith the normal exigencies of our daily lives, neither is so extraordinary in the context of the cohort of patients who present daily to A&E following concussive or acceleration-deceleration-rotation head injuries. Neither L or S was offered high resolution neuroradiological scanning during the acute post-accident phase of the symptoms. That is representative of the head injury protocols in UK casualty departments.

8. It is estimated that roughly to 80% – 90% of all brain injuries fall within the mTBI umbrella, as opposed to more severe and obvious brain injuries characterised by long periods of unconsciousness, skull fracture, or neuroradiological findings of macroscopic diffuse axonal injury or subdural or subarachnoid haematoma.

9. This mild concussive head injury patient cohort is frequently dismissed by both the medical and legal professions, with any subjective reported cluster of symptoms being typically attributed to short lived psychological factors. Being dismissed and/or ignored in this way, especially when the symptoms persist beyond the expected prognosis deadlines, often leads to confusion, despair and secondary psychological decompensation.

10. As lawyers, we need to devise systems that screen for this patient cohort to ensure that their symptoms are properly investigated by appropriately experienced medico-legal practitioners in the correct clinical disciplines, capable of taking detailed and reliable clinical histories and assessing them appropriately, to ensure access to justice.

Mr Long's medical case

11. Mr Long (L) accepted that he had a significant pre-existing medical history of fibromyalgia which involved somatoform symptomatology. His claim was presented on the basis that he was functioning well at the time of the accident and that he sustained a mild traumatic brain injury (mTBI) and thereafter went on to develop Functional Neurological Symptom Disorder (FNSD) and Neurocognitive Disorder due to Traumatic Brain Injury with behavioural syndrome, none of which would have developed spontaneously in the absence of a concussive head injury.

12. He reported a variety of symptoms that severely compromised his ability to work or function normally, namely: memory problems, migraine, difficulties with concentration and problem-solving, word finding difficulties, polyopia (multiple visual images), vertigo, balance difficulties, fatigue, anger, evolution, light and noise sensitivity in the symptoms of a severe depressive disorder.

13. The Defendant, Elegant Resorts (ER) denied that the circumstances of the accident were capable of, or in fact did, cause a mTBI; insofar as L presented with any genuine symptoms following the incident at work, they were merely an extension of a pre-existing somatic symptom disorder, (SSD). ER was sceptical both of the accuracy and honesty of L's account relating to the accident and its aftermath contending that he was an unreliable and contradictory witness and that he had lied about the circumstances of his post-accident redundancy. ER pleaded a defence a fundamental dishonesty relying on section 57 of the Criminal Justice & Courts Act 2015 inviting the Court to strike out the claim.

Mr Stansfield's medical case

14. Mr Stansfield's (S) case had the advantage that S was physically strong and psychologically resilient before his crash tests and had no prior vulnerability to developing the symptoms that followed. He reported enduring chronic pain in the spine, head and face, visual disturbance, tinnitus, headaches, migraines, dizziness, nausea, vertigo, disturbed sense of smell, fatigue and reduced mental stamina, sleep disturbance, intolerance / sensitivity to noise and light, cognitive difficulties and personality change.

15. The BBC's accepted that suffered a moderate whiplash injury with depressive symptoms but denied that he sustained any brain or audiovestibular (AV) injuries and put him to

proof of his claim, citing the *dicta* in *Pickford v. ICI* [1998] 1 WLR 1189 that required a Claimant to prove the medicine underpinning his claim in circumstances where '*the case involves the assessment of complex and disputed medical evidence*'.

16. The BBC elected not to allege that S was guilty of deliberate fabrication although it did challenge his credibility in relation to parts of his evidence. Instead, the thrust of its case was to assert positively that there was no organic injury in terms of mTBI or AV damage, and that in the absence of independent scientific cooperation of such damage by reference to objective neuroradiological data, the court should find that S had failed to prove the causal nexus between the crash test and the subsequent subjective presentation of poor health.

Analysis of the presentation of symptoms in the acute phase and PTA

17. Both judgments devoted considerable attention to the evidence of symptoms over the first 24 hours, and thereafter over the first 28 days following the triggering event (the acute phase).

18. S's case was unique because each of the low speed crash tests was captured on a high-speed digital camera. The Court was able to view the mechanism of injury in real time and slow motion. Furthermore there was footage of S after each crash test. Specifically, 40 minutes after the 4th crash test, he was filmed engaging in a pre-scripted interview with a contributor to the programme. Roughly 2 hours after the final crash test he was filmed again delivering a 28 second piece to camera.

19. The Court found that the film footage was a poor medium to exclude brain injury. In the first section of film involving the prescriptive interview there was minimal sign of cognitive impairment. There were clearer signs of cognitive impairment at the two hour marker when S required multiple takes to deliver his 28 second piece to camera, which was extremely unusual for him before the crash tests.

20. In neither case was a prospective post traumatic amnesia (PTA) history taken by treating clinicians. In S's case his medicolegal neurologist assessed at the 7th anniversary of the accident and was unable to take a reliable retrospective PTA history at that stage. The court found that PTA could neither be ruled in or ruled out by viewing the film footage of S after the crash tests, and found on balance but as there was no clear evidence of PTA in the film footage, but any PTA that there was must have been short lived.

21. In L's case, ER contended through its neurological expert that there was no PTA because an eye witness to the accident confirmed that L did not appear confused or disorientated at any point following the blow to his head, and was capable of engaging in lucid conversation and normal activities, to include speaking to his manager on the phone and going off to get some blue towelling to stem the bleeding to his forehead.

22. The Court rejected that evidence, finding that there was probably a period of a few minutes of PTA covering a period when L consistently reported that he had laid down no memory of events at all until a recollection of sitting on a bench in a different part of the building to where he was injured. The Court accepted L's neurological expert's evidence that PTA was not the same as post-traumatic confusion and accepted that it was '*possible to be lucid and alert and appear normal and yet still be within a state of PTA*'. Importantly, D's expert

agreed that head injury patients '*may not present as disorientated, agitated or confused, yet still have suffered mTBI*'.

23. It was the evidence of Mr S's wife at approximately six hours after the last crash test, he came home in an '*unusual state, ranting and raving behaving in a strange manner; he was agitated, frightened and wild eyed, confused, incoherent and repetitive*'. He did not know how he had got home from work.

24. S's neurologist provided a neurological explanation for this delayed onset of more severe neurological symptoms as forming part of the '*neurometabolic cascade*' which is reported in the clinical literature following acceleration-deceleration-rotation injuries of the brain. BBC's neurological expert acknowledged that this neurometabolic cascade formed part of the normal physiological healing process. The court accepted that the delayed deterioration in S's symptoms were signs of neurological impairment. The concept of the neurometabolic cascade was mentioned in passing in the judgement in *Long*.

mTBI can be the gateway to debilitating overlap injuries

25. The Defendant's neurological expert in both cases acknowledged from the published literature and his own experience that there were patients who could be described as having mTBI and who would normally be expected to go on and make a full recovery but who instead go on and have ongoing symptoms. He acknowledged that such patients '*are the subject of great interest and focus*'.

26. In L's case, ER's neurological expert accepted the proposition that '*people with pretty innocuous head injuries sustained in sport to have had enduring symptoms go on for many years*'. The Court went on to observe that '*there was no basis to distinguish head injuries sustained during the course of sporting activities from those sustained in other circumstances and that it followed that evidence of severity of impact is a relatively poor indicator of the likelihood of a person suffering mTBI*'.

27. These observations segue into the importance of looking at possible overlap injuries in particular in the fields of AV medicine, chronic pain and neuropsychiatry.

Importance of AV medicine in the consideration of mTBI, to include post-traumatic headache / migraine and tinnitus

28. AV medicine is complicated and is poorly understood by the legal profession and by some sections of the medical profession too.

29. 31 paragraphs of the *Stansfield* judgment was devoted to setting out the AV issues arising in that case. S was not assessed by an AV physician for medico-legal purposes until the 5½ year anniversary of the accident. That assessment revealed objective evidence of subtle left-sided impairment in S's high frequency vestibular function; specifically moderate left-sided damage involving the left utricle and semi-circular canal that mediated S's gravitational and angular motion sensors together with post traumatic migraine.

30. Part way through cross-examination, BBC's AV expert agreed that these clinical findings were reliable and evidence of organic damage to S's AV apparatus. Further, it became clear that no other clinician or expert had properly tested S's high frequency vestibular function. Instead, AV testing had been confined to assessing his low and mid frequency

vestibular functioning, which were either normal or equivocal; consequently, objective scientific evidence of organic damage was missed by everyone save for S's AV expert; this oversight in the methodology contributed to the BBC's positive defence that there was no organic evidence of AV injury.

31. BBC's AV expert was also L's expert in the ***Long*** case; in that case he stated in evidence: '*we know that any knock on the head can trigger a migraine. You know I have seen people in my clinic who have just knocked their head getting into a car and they can develop migraine and it's very well-established that even mild head injuries can trigger migraine*'

32. Post traumatic migraine played an important role in both cases in explaining the periodic episodes of deteriorating and improving levels of cognitive function. In both cases the court found that there was post traumatic headache, specifically migraine, aggravated by physical, cognitive and psychological loading, giving rise to episodic periods of significantly reduced function. This scientific explanation neutralises and contextualises an oft-quoted epithet by defendants that brain injuries don't deteriorate over time.

33. Finally, the importance of the post-traumatic tinnitus, which presented over the course of several weeks after the accident and remained a significant enduring feature of Mr S's presentation, should not be overlooked. Tinnitus in and of itself in the absence of any other symptom can potentially be debilitating, especially for any patient earning a living in executively demanding white-collar employment where the presence of intrusive tinnitus can negate one's ability to concentrate and function optimally.

Overlap neuropsychiatric symptoms against the backdrop of mTBI

34. Both cases featured important neuropsychiatric sequelae to coping with the organic effects of mTBI and AV injuries. In addition, S was left with acute chronic neck pain emanating from his cervical-cranial junction that represented a significant additional drain on his cognitive and mental stamina.

35. Both L and S engaged in executively demanding employment. Both experienced progressively increasing anxiety and depressed mood in response to their heightened awareness that they were unable to cope properly with the demands of their employment.

36. In L's case, his employer elected to make him redundant shortly after his accident, which he perceived was prompted to his medical incapability of work. That perception exacerbated his underlying neuropsychiatric response to the enforced lifestyle changes brought about by the symptoms of the head injury, which triggered a severe depressive episode within 2 months of the accident.

37. S was self-employed and committed to multiple projects which he endeavoured to continue for c. 12 months after the crash tests, following which his attempt to buffer the symptoms of head injury which brought about a physical and emotional breakdown, forcing him off work; his psychiatric state deteriorated at that point.

38. A common feature of this these two cases, and indeed most cases involving mTBI, is a lack of awareness on the part of the patient, and invariably also their treating clinicians, of any organic injury beyond possibly soft tissue whiplash type diagnoses. Invariably, the clinical advice is the same, namely that they should attempt to carry on with normal day-

to-day activities in the expectation of making a full recovery by the 6–12 month anniversary of the accident.

39. Furnished with such advice, it is the normal response of this patient cohort to attempt to carry on as normal at work, employing coping strategies premised on self-denial and sometimes even deception, in order to present to employers and colleagues that there is nothing cognitively wrong. There is a stigma associated with cognitive and psychological dysfunction, a stigma that is particularly acute in the milieu of a white-collar workplace.

40. One of the reasons that Mrs Hibberd-Little, who was a teacher, failed to discharge the evidential burden of demonstrating a post-traumatic head injury in ***Hibberd-Little v. Carlton*** [2018] EWHC 1787, was that the Court could not reconcile her self-report of a cluster of symptoms consistent with mTBI with the absence of any corroboration in her clinical records over a 24-month period post-accident.

41. The fact that this patient cohort often is made to feel disenfranchised by the healthcare system contributes to such maladaptive coping strategies. Often, it paves the way to heated and unpleasant litigation.

42. In L's case, his descent into psychiatric dysfunction was the prominent part of his post-accident presentation. Within two months he was diagnosed with a depressive disorder and prescribed antidepressants. By five months he was demonstrating suicidal ideation and shortly thereafter required a lengthy admission into a psychiatric unit. Thereafter, he presented with debilitating persistent low mood and intermittent suicidal ideation. Throughout it all, he presented with profound cognitive dysfunction of the sort commonly associated with the aftermath of brain injury.

43. In light of the modest nature of the brain injury sustained, coupled with his profound psychiatric presentation, from about the second anniversary of the accident, L's neuropsychiatric expert applied the diagnosis of Functional Neurological Symptom Disorder (FNSD) Neurocognitive Disorder due to Traumatic Brain Injury with behavioural syndrome, combined with Major Depressive Disorder to explain his enduring presentation. He found that L also had pre-existing chronic fibromyalgia characterised by somatoform tendencies and a personality type which would respond poorly to trauma, explained his presentation.

44. The parties instructed neuropsychologists who carried out a battery of neuropsychological tests. L failed all the effort tests comprehensively with both experts. That failure was relied upon by ER to seek to discharge its legal burden of proving fundamental dishonesty. The Court accepted C's expert evidence that effort test failure was a common feature with FNSD patients, and that the failure was a feature of his psychological illness rather than any conscious intention to deceive for financial gain.

45. The Court rejected ER's positive case that the post-accident descent into psychiatric disorder was merely a continuation of a pre-existing SSD aggravated by an unrelated redundancy and conscious exaggeration.

46. In S's case, his descent into psychiatric illness was more nuanced and more delayed. At the time of his psychiatric expert's first assessment 3¾ years post-accident, he presented with symptoms of a Major Depressive Disorder with post-traumatic symptoms. S's

premorbid personality was also relevant in understanding his post-accident psychiatric presentation. He was noted to be 'alexithymic', i.e. instinctively resistant to psychological weakness or explanation. S embarked upon a concerted effort to explore a physical explanation and treatment options for his symptoms from multiple practitioners over the years in his quest for a recovery.

47. In my experience, this personality type is common, particularly with high functioning alpha males and also with clients from ethnic backgrounds that stigmatise mental illness, equating it with personal failure and moral weakness.

48. As the years passed and S's cluster of symptoms became increasingly entrenched, his preoccupation with his health satisfied criterion B of the psychiatric diagnosis of Somatic Symptom Disorder (SSD). Importantly, this diagnosis did not displace the diagnoses of mTBI, chronic pain from the whiplash injury, tinnitus, migraine and the left-sided AV injury; instead it complimented those diagnoses which contributed to a complex medical presentation.

Importance of standing back and looking at the medical evidence in the round

49. Neither L or S could have proved his case without his team of experts standing back and acknowledging the overlapping and interacting nature of their respective disciplines in describing the overall presentation.

50. It is clear from the two judgments that neither Court was prepared to dismiss either claim as being 'medically unexplained' on a balance of probabilities. Equally, in the ***Long*** case, the Court was not prepared to find that D's assertion that L's presentation to the experts and the Court was mediated by dishonesty.

51. The cases are important because they signal confirmation by the Courts that the state of medicine in 2021, particularly neurological medicine reflecting knowledge of mTBI, is such that there is a potentially large cohort of head injury patients who suffer trauma to the head, either in the form of a concussive blow as with L, or acceleration/deceleration/rotation trauma to the head, as with S, that can leave no trace evidence on neuroradiological scanning and yet cause the patient lasting debilitating symptoms capable of affecting the function in their normal work and home lives.

52. As lawyers, the reasoning underpinning these judgments should cause us to ask ourselves how many injury clients we see who are sent away with confirmation that they have not sustained any significant head injury, and see their cases settled on the basis of short lived post-traumatic psychological symptoms and empty platitudes that they will likely make a swift recovery post-(under)settlement of their litigation.

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