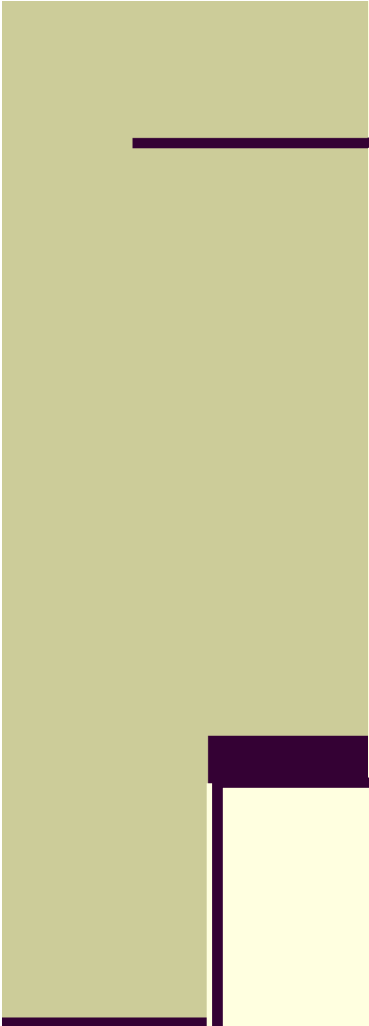


**Recent Developments in the “Thin
Skull” Rule: Medical and Legal
Implications for TBI Survivors with
Pre-Trauma Impairments**

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"Traveling Together: Navigating the System to Achieve Success After Brain Injury"



The Thin Skull Rule

- One who causes harm is held responsible for the victim's uncommon or unforeseeable reactions to the injury.
- Example: John causes a minor scrape to Jack's arm. Jack, a hemophiliac, suffers disabling blood loss.
- *John is liable for the full extent of Jack's injuries even though the harm to another person would have been minor.*

The Thin Skull TBI Survivor

What are the Pre-morbid factors?

Pre-morbid Factors -General

Pre-Morbid Personality

- Hyperactive
- Impulsive
- Antisocial and aggressive
- Obsessive – compulsive

Pre-Morbid Psychiatric Syndromes

- Depression
- Anxiety
- Psychosis
- Family Psychiatric History

Environmental Factors

- Substance use - Alcohol
- Drugs

Amount of Brain Damage

Emotional Impact of Injury

Emotional repercussions of Injury

Response to intellectual impairments

Development of Epilepsy

Compensation and Litigation

Additional Pre-morbid Factors in Children

- Marital separation of the parents
- Increase in arguments between parents
- Death of a close friend
- Change in father's occupation with increased absence from home
- Suspension from school
- Acquisition of a visible deformity

Children often present with:

- Learning Disabilities
 - “Failure to learn despite adequate general intelligence ”
- Behavioral Dysfunction
- Attention / Hyperactivity Problems
- Speech or Language Difficulties
- Impulse Control Disorders
- Conduct / Pervasive Developmental Disorders
- Psychosis
- Atypical Anxiety and Depression

Additional Pre-Morbid Factors in Elderly

- Increase in arguments between partners
- Marital separation
- Death of a close friend / emotional supports
- Loneliness / Isolation
- Medical Infirmary
- Pre-morbid Cognitive Impairment
- Lack of emotional fulfillment – career, goals ...

Elderly often present with:

- Cognitive deficits out of proportion to injury – Catastrophic Reactions
- Somatic preoccupation
- Worsening of medical conditions
- Illness of partner
- Depression, Anxiety AND Psychosis (Paranoia)
- Isolation, Dependence

What this means:

- Assessment has to be thorough
 - LOC, PTA, RA, or GCS are not the end-all in predicting subsequent difficulties
- Information from as many sources as possible; family, friends, relatives, school, co-workers, employer, man/woman next door ...
- Psychiatric problems especially depression occur later (after 6 months) and therefore patients should be followed up
- All unexplained symptomatology is NOT Malingering
- Management has to be multimodal – BIO-PSYCHO-SOCIAL
- Patients are genuine unless proven otherwise

Essential Purpose of Tort Law

“Restore the victim to position she would have enjoyed had defendant not harmed her”.

“Thin Skull” Rule in Law Suits

- Victim must prove that “more likely than not defendant caused or contributed to injury”
- Not necessary for victim to show defendant’s conduct was *sole cause*
- Victim must show defendant “*materially contributed*” to her injury

Multiple Causes of Impairments

Athey v. Leonati : Supreme Court of Canada

“Since most events are the result of a complex set of causes, there will frequently be [noncompensable] contributing causes”.

“As long as a defendant is part of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury”.

Multiple Causes of Impairments

Athey

“Apportionment [of responsibility] between [compensable] and [noncompensable] causes is contrary to the principles of tort law, because the defendant would escape full liability even though he caused or contributed to the victim’s entire injuries. The victim would not be adequately compensated, since the victim would not be placed in the position he or she would have been in absent the defendant’s negligence”

The “Crumbling Skull”

If the victim’s condition was deteriorating before the accident and the defendant proves that the deterioration would have continued regardless of the accident, then *“this can be taken into account in reducing the overall award”*.

Medical and Rehabilitation Benefits for the Thin Skull Victim

The Bill 59 S.A.B.S:

“*Accident*” “...incident in which the use or operation of an automobile *directly* causes an impairment”.

Stargratt and Zurich

Where accident is “*a significant factor*” in worsening or hastening pre-morbid condition, the accident is held responsible for “*directly causing*” an impairment.

Medical and Rehabilitation Benefits for the Thin Skull Victim

- *Exacerbation of Pre-morbid Conditions*
- *Hearn and Allianz Financial Services*

Commission:

“This Commission has repeatedly held that the accident need not be the only cause of the subsequent injuries, but rather, must significantly or materially contribute to the ...impairment.”

Example 1: LUCY

- Grade 3 special needs student with diagnosis of ADD in grade 2. Parents separated in grade 1. Mom lives with her and sister in a 2 bedroom apartment. September 12/02 Motor Vehicle Accident. Hit in cross walk. GCS of 8 at scene. Taken to HSC initially. Post- traumatic amnesia of 3 hours. Retrograde amnesia of 3 days.

Recovery in HSC for 2 weeks. Then to Bloorview MacMillan Centre for 5 weeks. Emphasis on reengaging in peer play and school activities. Impairments on discharge identified as word finding, concentration, anxiety, lability, fatigue, and impulsivity.

- What are the accident related recommendations for rehabilitation on discharge?
 - modalities
 - housing
 - transportation
 - attendant care
 - family supports
 - case-manger
- How to prove?
- What records required?
- Triggers required in treatment plan / consultation note to access treatment.
- Strategies to engage most success in reintegration having regard to pre-morbid factors.
- Tort recovery.

In example 1, the following may apply:

- Pre-morbid Personality
 - ADD
 - Hyperactive
 - Impulsive
 - Pervasive Developmental Disorder / Oppositional Developmental Disorder
- Marital separation of the parents - Yes
- Increase in arguments between parents - Probably
- Death of a close friend - No
- Change in father's occupation with increased absence from home - Yes
- Suspension from school - No
- Acquisition of a visible deformity – No
- Assessment has to take into account pre-morbid conditions and probable exacerbation of dysfunctions after MVA
- Treatment has to address pre-morbid conditions, post-injury exacerbation, family dysfunction, housing issues, emotional / physical support in addition to standard neuropsychiatric care

Example 2: TOM

- 27. Painter apprentice. Separated. Father of 7 year old child who lives with mother. Getting counseling for anger management. August 12/02 accident. Hit and run driver. Tom was pedestrian. Lives on own. Doesn't drive. Hit crossing road having consumed 10 drinks at local bar. No witnesses. Found on street by passersby unconscious. Ambulance attendants tested GCS of 8. Has fractured displaced acetabulum and closed head injury. Diffuse hemorrhage, frontal and parietal area. Smoker. Nonunion of fracture sight. Taken to Toronto Western. 3 weeks recovery then discharge to Toronto Rehabilitation Institute for inpatient rehabilitation. Noncompliant. Aggressive. Wheelchair bound. Testing shows functional illiteracy (Grade 4 level reading). Severe headaches. Partially ambulating on discharge.
- What are the accident related recommendations on discharge?
 - case-manager
 - modalities
 - housekeeping
 - family reintegration
 - vocational reintegration
 - cognitive and physical therapies
 - level of benefit entitlement
 - How to prove?
 - What records required?
 - Triggers required in treatment plan / consultation note to access treatment
 - Strategies to engage most success in reintegration having regard to pre-morbid factors

In Example 2, the following may apply:

- Pre-morbid Psychiatric Conditions
- Anger
- ? Substance Abuse / Dependence
- ? Personality Style / Disorder
- ? Intellect
- Acquisition of a visible deformity – Yes
- Post-MVA frontal lobe deficits can exacerbate pre-morbid pattern of behavior
- Assessment has to take into account pre-morbid conditions and probable exacerbation of dysfunctions after MVA
- Treatment has to address pre-morbid conditions, post-injury exacerbation, emotional / physical support in addition to standard neuropsychiatric care especially lack of insight leading to non-compliance

Example 3: GERTRUDE

- 82 year old passenger with early onset dementia but living independently in first floor of 2 floor duplex. Daughter lives above. While passenger in daughters car, struck on passenger side. Orthopedic injuries and loss of consciousness for five minutes. Disorientated with GCS of 11 when ambulance arrives. Orthopedic injuries does not heal properly. Can't ambulate independently. Relation with daughter poor. Believes daughter taking her things. On discharge won't let others clean her flat. Daughter can't manage care and constant needs of her mother.
- What are the accident related recommendations on discharge?
 - case-manager
 - modalities
 - housekeeping
 - family reintegration
 - vocational reintegration
 - cognitive and physical therapies
 - level of benefit entitlement
- How to prove?
- What records required?
- Triggers required in treatment plan / consultation note to access treatment
- Strategies to engage most success in reintegration having regard to pre-morbid factors
- Tort recovery

In Example 3, the following may apply:

- Increase in arguments between partners - No
- Marital separation - No
- Death of a close friend / emotional supports - Yes
- Loneliness / Isolation / Dependence - Yes
- Medical Infirmary - Probably
- Pre-Morbid Cognitive Impairment - Yes
- Lack of emotional fulfillment – career, goals ... - Yes
- Acquisition of a visible deformity – Possibly
- Depression, Anxiety AND Psychosis (Paranoia) - Yes
- Assessment has to take into account pre-morbid conditions and probable exacerbation of dysfunctions after MVA
- Treatment has to address pre-morbid conditions, post-injury exacerbation, family support, housing issues, in addition to standard neuropsychiatric care