

able. Mrs Primrose returned for assessment six months later. This assessment's results confirmed the initial examination.

It was argued that given Mrs Primrose's age at the time, this injury merely exacerbated a natural degeneration. Reports from family and friends corroborated that Mrs Primrose was in sound health with no family history of early dementia, Alzheimer's or Parkinson's disease etc. In fact, two years prior to assessment Mrs Primrose was examined by another Neuropsychologist. My assessment showed slight improvement in cognitive functioning. Degenerative diseases would have seen deterioration.

The weight of evidence from medical and allied specialists, and the earlier assessment suggested that Mrs Primrose sustained closed head injury, and cognitive deficit due to closed head injury by impact of a golfball.

#### Golfing caddy

Case study number two involves a young (16 year old) male golfing caddy who was also struck on the side of the head by a golfball travelling at speed from a distance. Mr James experienced no unconsciousness following injury, however, he did report that he "fell asleep for two days" about six hours after the injury.

Two days later, Mr James experienced a grand mal seizure. Three weeks later, he experienced a further grand mal seizure. Four months later he experienced two petit mal seizures.

Fortunately, just prior to injury, Mr James had undertaken a Wechsler Intelligence Scale For Children - Revised in application for a Year 11 scholarship. This assessment showed Mr James' IQ to be at Superior level. Intelligence scores ranges from Mentally Defective through Borderline, Below Average, Low Average, Average, High Average, Superior to Very Superior. Based on his IQ and scholastic performance to date Mr James received his scholarship and planned a career in psychology and law. The injury occurred during the holidays before the start of Year 11.

When Mr James returned to the schooling environment, he noticed increasing difficulties with concentration, attention and comprehension. Dismissing these as 'senior school nerves' he persisted with study and attended tutoring. After

three months, the cognitive difficulties had not abated. Half-year reports were disappointing with the usually A+ student, performing at the B- and C level.

Psychologically, Mr James developed depression and anxiety. His parents dismissed this initially as 'hormonal' and part of growing up. Physically, Mr James was far less co-ordinated, had poorer balance and was unable to enjoy normal sporting activities.

One year following injury, Mr James presented for assessment. Tutoring, counselling, and medication had proven ineffective and yielded no explanation. Assessment revealed Mr James' intelligence had significantly decreased in comparison to one year earlier. His IQ was now at the Average to High Average level. No other evidence explained this decline except the closed head injury. Assessment also revealed significant deficits in short-term auditory memory, attention, concentration, and visual memory. Malingering tests were negative, results considered reliable.

Personality assessment indicated Major Depressive Disorder and Generalised Anxiety Disorder. Conference with parents and teachers regarding pre- and post-injury behaviour, school performance and health, combined with the weight of evidence from assessment, led to the opinion that the golfball injury resulted in cognitive deficits due to closed head injury.

These two cases demonstrate that neuropsychological damage is possible from a single injury by a golfball. Both cases yielded such similar cognitive, psychological and physical symptoms despite the obvious differences in gender, age, and pre-accident ability. These are not isolated cases, I have had cause to examine many dozens of sports injuries resulting in neuropsychological deficit.

Given that golfballs are small, and do not frequently impact with human skulls, we can only postulate what amount of damage is sustained under the weight of baseballs, cricketballs, and repeated pounding in sports such as boxing, and football. ■

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## Death-bed hearings outlawed

TRACY SUTHERLAND

**PEOPLE** dying of asbestosis and mesothelioma will no longer be subject to distressing death-bed compensation hearings, under laws announced by the NSW Government yesterday.

Introducing the first laws of their kind in Australia, Attorney-General Jeff Shaw said the Government would end a bar on general damages being paid to the families of victims who died before their compensation claims were finalised.

"The changes will put an end to the harrowing death-bed hearings that have been necessary in the past," said Mr Shaw, adding that people endured the hearings in a desperate attempt to secure the future of their families before they died.

Mesothelioma sufferers commonly have less than a year to live after being diagnosed, often making bedside hearings unavoidable.

Due to its historically high level of asbestos use, Australia has the highest incidence of mesothelioma per capita in the world, with NSW accounting for up to 40 per cent of these cases. Around 100 people die of dust diseases each year in NSW.

Robert Favelle's 79-year-old father Alex died of mesothelioma two weeks ago, after working as a boilermaker among ship steam pipes containing asbestos.

Mr Favelle said his father clung painfully to life to finalise his \$130,000 compensation claim just a day before he passed away.

"It was very painful for the family to see him hanging on," said Mr Favelle. "The impact was that it made him weaker, he was having to force himself to stay awake to answer questions."

Had the bedside hearing not been necessary two weeks ago, "it would have taken a great load off my father's mind", Mr Favelle said.

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