THE BRITISH ASSOCIATION OF BRAIN INJURY CASE MANAGERS

BaBiCm

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Chairman's Address

It is every new Chair's prerogative, and I am no different, to review the past and to try to set out the way forward for the future. As I noted in the last newsletter 2006/07 was a difficult year, but we have a new council with a number of new members and I am full of hope for the future of BABICM.

Let me start with the council. We have 12 elected members and I have tried to ensure that everyone has a role and that for each role there are key responsibilities with goals for each member of council to achieve, including myself.

There are some changes in the council in that we have established the position of Vice Chair, so that I have someone who can deputise for me if I am not available and take over from me if I am not able to continue in the role. We have also given individual council members responsibility for the website, fundraising and sponsorship and publications as well as having the chairs of the special interest groups, and we have resuscitated the role of Council Secretary. I hope that with every council member having some key responsibility, each council member will make positive or viable contribution to the growth and development of BABICM. The responsibilities are as follows:

Chair
Cathy Johnson, *Rehab Without Walls*
Vice Chair
Nikki Ounsworth, *Bush and Co*
Council Secretary
Georgina Cooper, *Allianz Cornhill*
Treasurer
Caroline Ferber, *Anglia Case Management*
Treasurer to be
Anne Cossar, *Phoenix Therapy and Care Ltd*
Fundraising and Sponsorship
Carole Murray, *Rehab UK*
Website Manager
Mark Tempest, *Harrowell Shaftoe Solicitors*
Publications and Ethical Advisor
Paul Yeomans, *Partnerships in Care*
Chairs/Representatives of Special Interest Groups Training
Jackie Parker, *Jackie Parker Associates*
Professional Standards
Jo Clark Wilson, *Head First*
Children and Young Persons
Karen Burgin, *Bush and Co*

Features in this edition include:

Chairman's Address *cont.*

To those of you who did not attend the Annual Conference and AGM I would also like to introduce Poling Mann, our new administrator who works for BABICM for three hours each weekday morning. She is based in the offices of Northern Case Management and I would like to thank Carol again for her generosity in making her office available to BABICM. For the first time in our short history this means that the office will not be in the premises or vicinity of the chair.

I said above that I had given the chair responsibilities and goals to achieve and I will set them down here for future reference. I see my responsibilities as:

1. Chairing the Council to ensure that the business plan goals are met.
2. Publicly representing BABICM.

With these responsibilities I have a goal to produce a one year business plan by September 2007 (which will be very brief) and a three year business plan by June 2008. I also hope to develop and produce a strategic marketing plan for BABICM by June 2008.

Although it is not a specific goal, one of my intentions is to improve the working relationship that BABICM has with CMSUK. To that end I have accepted CMSUK's invitation to represent BABICM on their Ethics Committee and note that Paul Yeomans is also a member of this committee. I am committed to working with CMSUK to develop joint and acceptable standards for case managers in the UK and I know that Jo Clark Wilson is also committed and working to this end.

Hot off the press is the invitation BABICM has received to send a representative to the UK Rehabilitation Group, a new organisation currently in development. The invitation will be discussed at the next meeting of council.

I am looking forward to a busy but, I hope rewarding year.

CATHY JOHNSON

Care & Rehab

From this autumn **Leonard Cheshire Foundation** becomes **Leonard Cheshire Disability,** with a new logo emphasising the 'ability' bit.

Sovreign Capital, who own Tracscare (TRACS), acquired Parallel Options, the Gloucestershire-based domiciliary care agency.

The Hawthorns Rehabilitation Centre, County Durham (Barchester Healthcare) is looking for a first level registered nurse as Head of Neuro-Rehabilitation Services. For further information please contact Julia Atherton, General Manager 0191 5871251 or email *julia.atherton@barchester.com*

The Hornsey Trust for children with cerebral palsy is recruiting a chief executive based in north London. *www.hornseytrust.org.uk or email info@hornseytrust.org.uk*

BABICM

PO Box 199, Bury, BL89EL

Care Standards and CSCI-Where are we at?
Where are we going?
What every case manager needs to know

Wednesday 6th February 2008
in Newcastle area

The day is aimed at:
Practising brain injury case managers who are either in the process of registering with CSCI or are registered and not yet inspected or wondering if they should register or any case manager who wants to find out more about the implications of CSCI on their practice.

This workshop is being led by
Ella Cornforth of J S Parker & Associates
and
Linda Marsden of Anglia Case Management Ltd.

BABICM members will benefit from a reduced rate to attend as will anyone who books before December 6th 2007 (early bird offer).

Please contact BABICM Administrator for more details and a booking form.
07002 222 426 or Email - babicmsecretary.org

Professional Standards Group

The Professional Standards Group approached CMSUK in April 2007 regarding the joint standards, as requested by the Civil Justice Council and, when followed up recently, the chair of the Professional Standards Group, Jo Clark-Wilson has been informed that Carole Chantler will take this to the CMSUK Board.

The Professional Standards Group have highlighted four areas to concentrate on this year, which are the following:

1. Standards

To establish the joint basic case management stages in liaison with CMSUK and the specialist standards required for brain injury case management.

2.Ethics

To prepare an ethics document, in liaison with CMSUK

3.Membership

To review the membership criteria and peer review process

4.Professional Guidelines / Documentation

To develop clinical guidelines for case managers working in the field of brain injury

Members of PSG will lead these groups and the projects for the year. If you are interested in working with us, or if you have any views about these or any other areas of work, please contact Jo on ***jo.clarkwilson@head-first.org***

Publications

The Social Worker's Guide to Mental Capacity Law by **Robert Brown & Paul Barber** (21 September 2007) BMJ/Blackwell (£20) ISBN 9781844451296

Children & young people (CYP)

RTAs and under-15s

The number of under-15s killed on British roads increased 20% last year. Cyclist deaths in this group rose 55%. Conversely, the overall killed or injured figures have fallen steadily the past ten years, with child road injuries down 9%. Traffic levels have continued to rise. British drivers have a poor comparison with child fatalities: twice as many per head of population than France, Italy, Germany, Finland, Norway and Netherlands. Only Austria, Portugal, Poland and Ireland are worse in western Europe. Only cancer kills more 5-to-14-year-olds. Brake, the RAC Foundation, RoSPA and the Health Development Agency all commented on the figures:

- British kids are more likely to encounter faster road traffic
- They are less likely to use a marked crossing
- They use mobiles and iPods when walking or cycling
- They are more likely to be with other kids than adults
- They get driven places a lot
- Road safety, cycling proficiency and the 'Green Cross Code' equivalent is patchy
- Parents are more worried about drugs, weapons, and paedophiles
- Brits love to speed in high performance cars

Care

The white paper *Care Matters: Time for Change* (Cm 7137) was published in June 2007. It proposes the right to stay in care up to age 18 and foster care to age 21, also personal advisor support to age 26. National minimum standards for foster care would also be amended. Meanwhile a new care protocol will be introduced (see 'Legal' section).
www.dfes.gov.uk/publications/timeforchange

CAFCASS

The deputy head of legal services for CAFCASS (Children & Family Court Advisory & Support Service) reported that since November 2004 there have been no formal referrals to CAFCASS Legal by independent reviewing officers with a view to litigation against local authorities. In the 12 months to April 2006 CAFCASS lawyers had seven queries from IROs on the duty help line. These ranged from a threat by an authority to withdraw funding to take a looked after child to school, to a dispute with housing about multidisciplinary planning for a child. A revised practice note was issued in May 2007. CAFCASS Legal cannot dispense legal advice to IROs but without their referral CAFCASS cannot bring human rights or judicial review claims. (Hinchcliffe, M. (2007) CAFCASS and the work of independent reviewing officers. *Family Law* **37**: 748-749)
www.cafcass.gov.uk

Land of my Fathers

Compared to general education law, the SEN Code of Practice places considerable emphasis on listening to the child's views. But as with the general law being parent-oriented, it is the parent who has the right to appeal against the statement. In Wales the Children's Commissioner has expressed that this should be reviewed. However, the SENT rules now give the child the right to attend the hearing, address the tribunal and give evidence. Furthermore the LEA is required in its evidence to state what it understands the child's views are, or else why it doesn't know them. The Commissioner has also expressed concern that children with SEN have no access to an advocacy service, instead their parents have an independent supporter. That service is provided mainly by the Special Needs Advisory Project (SNAP Cymru) and they do try to ascertain the child's views as a matter of good practice. (Sherlock, A. (2007) Listening to children in the field of education: experience in Wales. *Child & Family Law Quarterly* **19**(2): 161-182)

National Assembly (2004) *SEN Code of Practice for Wales* 3.3
Children's Commissioner (2004) *Annual Report 2003-04* p. 35
Children's Commissioner (2005) *Children Don't Complain…*p. 67
SENT Rules 2001 (SI 2001/600 as amended SI 2002/2787)

The PEDS Model of Child Neuropsychological Rehabilitation

Introduction

When a child suffers a traumatic brain injury (TBI) or a brain injury as a result of medical negligence the consequences are serious and far reaching. Injury to the young brain will affect all subsequent development. The injury often limits educational progress, employment prospects and the chances of living a fully independent life. Up until recently there has been little research about how to intervene to help with these difficulties from a neuropsychological perspective. Despite established adult models of neuropsychological rehabilitation, child neuropsychological models are less well-developed. Recently evidence has been growing about the factors that are important in child neuropsychological rehabilitation. In this article we review this evidence and propose a new model of child neuropsychological rehabilitation. We feel it is important for case managers to be aware of this evidence and the possible ways of intervening in order to make informed choices about what service to recommend and commission.

What the literature says about child neuropsychological rehabilitation

Although historically, child neuropsychological rehabilitation borrowed extensively from adult models of brain function, recovery and rehabilitation, it is now acknowledged that these models lack the developmental and systems perspective (i.e. acknowledging and working with the different systems within which the child exists including their peer group, family, professionals/carers involved, and education system). The developmental and systems perspective is regarded as essential in producing change in childhood brain injury (Anderson & Catroppa 2006, Ylvisaker *et al.* 2005).

Developmental perspective: there is an interaction between development and brain injury such that the timing and nature of the injury, the stage of skills development and the social context of the child interact to determine the outcome for the child (Eslinger *et al.* 1999, Ylvisaker *et al* 2005). The interaction between brain injury and development is exemplified by the finding that the profile of behavioural and psychiatric and emotional disturbance (a common and persistent sequelae of child brain injury) may worsen over time (Schwartz *et al.* 2003, Ylvisaker *et al.* 2005). These difficulties are usually associated with damage to the frontal lobes, an area of the brain typically affected in closed head injury.

There is a growing emphasis on the interaction between childhood development and frontal lobe damage when designing and implementing behavioural intervention programmes for children with behavioural disturbance following a TBI. Traditional behavioural management methods require the capacity to learn efficiently from consequences. The ability to learn in this way is reduced significantly by frontal lobe injury (Rolls 2000, Schlund 2002). In recent years *positive behaviour supports* have been highlighted as more appropriate strategies for managing the behaviour of children with brain injury. They focus more on managing the environment (to prevent triggers to behaviour), rather than trying to shape and change behaviour. There is mounting evidence of the efficacy of this type of behaviour management (Feeney & Ylvisaker 1995, Ylvisaker 2003) including in the school environment (Pressley, 1995, Sweet & Snow, 2002, Ylvisaker *et al.* 2001). In addition, it is recognised that children with damage to the frontal lobes as a result of a brain injury have particular difficulty in planning and organising. Positive behaviour supports can also be used by the young person to compensate for these difficulties, for example by encouraging the young person to use graphic organisers and telephones and other specific organisational strategies, and through the provision and implementation of predictable and paced daily routines. Again, there is evidence of the efficacy of these types of intervention (Feeney &Ylvisaker 1995, Feeney & Ylvisaker 2003).

Systems perspective: there is an increasing body of research stressing the importance of *context-sensitive* neuropsychological intervention (e.g. Ylvisaker 2003, Ylvisaker *et al.* 2005). This approach argues that the best form of rehabilitation is that which integrates therapy into the child's everyday activities of daily life (ADLs) and routines at home, school, work and community life. In addition, in this approach, the role of the therapist after the initial period, is to act as a support system and for day to day therapy to be maintained by familiar people in the life of the child such as parents and teachers (Feeney *et al.* 2001, Feeney & Ylvisaker 2003).

What the literature says about the importance of the family in child neuropsychological rehabilitation

Psychosocial context and family function play important roles for recovery in childhood brain injury and it is recognised that there is a reciprocal relationship between family functioning and the neuro-behavioural disturbance of the child with brain injury (Anderson *et al.* 2001, 2005, 2006). Previous anecdotal evidence of the role of family functioning on brain injury recovery is now established in the literature such that there are

significant benefits in the scholastic, behavioural and emotional functioning of the child when the family is supported, for example, through cognitive and behavioural strategies to cope with and manage the child and their behaviour more effectively (Taylor *et al.* 2002, Wade *et al.* 2005, 2006 a, b, c).

Furthermore, the context-sensitive approach recognises the role of the family in the care and rehabilitation of the child with a brain injury (Feeney *et al*. 2001, Feeney & Ylvisaker 2003). It is acknowledged that because of these new responsibilities, the family must be assessed, prepared and empowered by the rehabilitation team to take its place as an integral part of the caring and rehabilitating process (Armstrong & Kerns 2003, Anderson et al. 2006).

The PEDS Model of Child Neuropsychological Rehabilitation

In the context of recent literature and anecdotal evidence from our own clinical work, we believe that neuropsychological recovery / development takes place within specific contexts. We have developed the PEDS model which stands for Physical brain, Executive functions, Development and Systems:

Physical Brain: The brain is a physical organ connected to the rest of the body. A healthy body results in a healthy brain. It is important to look at diet, exercise and rest in a holistic approach in order to promote development and recovery.

Executive Function: Brain injury nearly always results in executive system damage. This is because the executive system is associated with the front areas of the brain (dorsal lateral pre frontal cortex and ventral medial cortex). The front part of the brain is most vulnerable to injury due to the impact of the brain hitting the skull at speed. Executive systems include planning, organisation and self control of behaviour and these are often impaired as a result of brain injury. Expecting a child or young person to rely on these systems to produce change does not work. It is important to take the burden of change and control directly off the child/ young person. This can be done by managing the environment, ensuring that there is structured activity (often in form of a structured timetable) and preventing difficulties occurring wherever possible.

Development: Brain and neuropsychological development occurs within stages (see Reed & Warner Rogers, In Press). Children with brain injury often get stuck at a certain stage. There is a need to understand what stage the child is at and to provide strategies and teaching to facilitate development on to the next stage.

Systems: Children and young people exist within different systems. It is vital to take account of these systems in order to produce change. The systems around a child or young person include the family system, the education system, the child's peer group and his or her carers. Our experience is that there is the need to work directly with these systems in order to produce change. It is vital to work directly with the different systems as well as the individual to provide optimum recovery and development. This is less likely to happen within an institution removed from these systems.

The PEDS model requires a comprehensive assessment of the child, family, school and carers resulting in a range of relevant goal-directed intervention options.

Conclusion

In this article we have presented a new model for paediatric neuropsychological rehabilitation. The model is based on a review of recent research and on our clinical experience. We hope that this article will help inform case managers so that they can recommend and commission good quality services in order to help children with brain injury fulfil their potential.

Dr Reed, Dr Byard and Dr Fine are chartered clinical psychologists and neuropsychologists who have developed a new child neuropsychological rehabilitation service, Recolo UK Ltd, based on the PEDS model. Details at ***www.recolo.co.uk***.

Jonathan Reed, Katie Byard, Howard Fine

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Taking the P?

Do you use the expression PVS?

Unfortunately worldwide there is now discrepancy as to whether the P stands for persistent or permanent, and this discrepancy features in England & Wales court rulings, practice directions and even texts on the Mental Capacity Act 2005 and its Code of Practice. The Official Solicitor's practice note says permanent . The leading case says persistent . The Act does not refer to PVS but the Code says permanent . The *Oxford Textbook of Medicine* (OTM4) says persistent, as do Kumar & Clark *Clinical Medicine* and *Brain's Diseases of the Nervous System* . The OTM4 chapter was written by Jennett who invented the term PVS, but who has since stated the P should be dropped as it is poorly understood by clinicians and families alike. This is particularly important for advance decisions and misdiagnosis concerns.

For example, if clinicians think there are two discrete conditions, is it any wonder there has been misdiagnosis? If I make an advance decision and say "If I am in permanent vegetative state I don't wish to have life-sustaining treatment", what happens if my future doctor says "Aha! He's not in permanent vegetative state but persistent vegetative state, so this advance decision doesn't apply"? What if I say "If I am in persistent or permanent vegetative state"? That sounds good but the doctor might say "This man was confused when he wrote it and didn't appreciate the clinical meaning of these terms, therefore I won't abide by it." Would I be better off saying "If I am deeply unconscious with no prospect of recovery, and my brothers agree that my quality of life falls below *x* on the *y* rating scale, then I don't wish to continue life support"? It may be simply another case of the law hijacking a clinical term and defining it its own way (like mental impairment in the Mental Health Act 1983). Or it may be a term clinicians never used anyway. You say potato.

Paul Yeomans

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Training Group News

The new training group for 2007/2008 has met once since the AGM in June. I am pleased to say that we have three new members joining us this year and I confirm that the current group members are:

Jackie Parker (Chair), Caroline Ferber, Jackie Dean, Allison Saltrese Baz Earnshaw (minute taker), Tania Brown (new member), Mike Smith (new member), Nicola Outhwaite (new member).

Building on the successful year in 2006/2007 the training group has a number of events either planned or in the pipeline. But firstly I am sad to announce that the Families Workshop planned to take place in Leicestershire on 25th September has had to be cancelled as it was undersubscribed.

The training calendar for 2007-2008 is shaping up:

2007

July	Successful workshop for Advanced members-Cambridge
August	No event
September	Training group meeting Families workshop cancelled
October	No event
November	Training group meeting. Planning meetings and advertising of events for 2008
December	No event

2008

January	Training group meeting 15th BABICM and Exchange Chambers, Manchester are planning to host an all day event at the Museum of Science and Industry, Manchester, entitled: 'The Funding of Rehabilitation and Care-Who Pays?' The day will be chaired by Bill Braithwaite QC and promises to be a lively event. Currently in the planning stages, it is hoped that the event will be advertised shortly. There will be an early bird booking opportunity so be ready to take advantage of this.
February	6th CSCI workshop to take place in the North East. Book early to ensure your place.
March	A second meeting of the Business Forum is planned. Details to be advertised by the end of the year.
April	Training group meeting
May	We have a number of possible events planned during April and/or May. Details will appear in the next newsletter
June	4th - the day before the Summer conference we will definitely be hosting a small workshop event-details to be confirmed. 5th-2008 summer conference. Venue has yet to be agreed and the planning group is to meet shortly to agree on the topic and speakers. Early bird booking will be available and we are hoping also to offer a special rate for dinner, bed and breakfast at the hotel.

Being involved in thinking about training events for BABICM is exciting and we are not short of ideas, however we do need to ensure we target our limited energies and resources so that we can provide a stimulating programme of events specifically targeted at the needs of our members.

We are all busy as are you, but I would love to hear from you. Let us know your views about any BABICM event you have attended-good or bad. Let us know if you have any ideas for events or any interesting speakers or trainers we could approach. And let us know if can help in any practical way…offers of help are always welcome!

The full programme should be finalized by the time the next newsletter comes out in December/January. In the meantime keep an eye on your emails and the BABICM website for advertising of events, and PLEASE book early so that we know if an event is going to be viable.

Jackie Parker
Chair of the training group
jackieparekr@jsparker-associates.co.uk

Risk Assessment & Management in Acquired Brain Injury Services

Approximately 12 months ago, members of BABICM received a questionnaire asking about their experiences of the risk management process. The questionnaire was also distributed through UKABIF and the BPS Division of Neuropsychology, as well as three local ABI services. The research project was funded by Lancaster University. We would like to thank you for your participation and offer some feedback on its findings:

Overview

The research project was an anonymous questionnaire-based survey of attitudes towards the risk assessment process, from the perspective of professionals involved in acquired brain injury services. The questionnaire was produced following a review of relevant literature, policies and legislation at local and national levels. After professional review and ethical approval, the final questionnaire was distributed to three services, and posted to the members of three national professional bodies.

Results

177 questionnaires were returned and analysed using; principle components analysis, post-hoc statistical tests, and thematic analysis as appropriate. Three factors were identified as underpinning effective risk assessment/management processes. They were given the labels; User-friendliness, Person-Centeredness and Coherence. Additional analysis considered the amount of training participants had received in this area, with levels ranging from none (35%), through to regular continued professional development courses (17%).

Qualitative data analysis identified themes relating to the risk process. Positive themes included its benefit in guiding interventions, and the usefulness of multi-disciplinary input. Thematic analysis of responses also identified areas for improvement. Participants made particular reference to the need for standardised and streamlined procedures and communication pathways. Respondents also commented on the need for less restrictive and more supportive formats (both for professionals and service users).

Additional Discussion Points

Synthesising quantitative and qualitative data highlighted the salient factors participants believed to be important in effective risk management. In addition to the statistical validity of the 3 factors (User-friendliness, Person-Centeredness and Coherence), there is also face validity for incorporating these features into all aspects of the risk management process, including; protocols, training, documentation, implementation and communication.

Participants commented on the need for better information from referral sources, and an overwhelming majority (n = 114) said that they did not communicate their own findings to other services.

Furthermore, service users were reported to have minimal involvement in decisions about risk assessments, or in the formulation of management plans. Streamlining the process may help to improve these relationships, without de-prioritising safety in care.

Finally, areas for further research may consider:

Training: Its effect on clinicians' confidence and skill-base Links between theory and practice Integration of generic and specific skills

Management: Development of a risk management model applicable across services.
Tailoring structures to individual service needs
Responding to crisis / occurrence of risk issue

Affect: Emotional consequences for clinician and client
Therapeutic support after incidents

Further Information

This is a brief summary, if you have any specific questions or would like further information please contact one of the primary researchers:

Stephen Weatherhead
07775 644 760
s.weatherhead@lancaster.ac.uk

Gavin Newby
01244 389 252
gavin.newby@wcheshirepct.nhs.uk

Legal update

The Ministry of Justice has a consultation running on deprivation of liberty safeguards under the Mental Capacity Act 2005 (runs 10 September to 2 December). The site contains draft regulations and addendum to the Code of Practice.
www.justice.gov.uk/publications/cp2307.htm

The Court of Appeal considered the offence of causing or allowing the death of a child or vulnerable adult, specifically 'significant risk of serious physical harm'. The trial judge's explanation to the jury it meant 'more than merely minimal risk' was a misdirection. Significant bore its ordinary meaning and it was the jury's decision whether risk was significant and whether the defendant was (or ought to have been) aware of it. The child was 4 months old, assaulted by mother's partner and mother failed to seek medical attention. Weeks later the partner hit the child on the head causing their death. (Domestic Violence, Crime & Victims Act 2004 section 5(1)(c); *R v Mujuru and Stephens* [2007] EWCA Crim 1249)

Local authorities in England must appoint a Director of Children's Services from 1 January 2008 to carry out their functions under section 18 of the Children Act 2004. These include: LEA, social services, joint NHS and local authority commissioning, care leavers, personal advisers, pathway plans, advice and assistance, employment, education and training, information, representations (complaints), interagency cooperation, welfare promotion, databases, and local safeguarding children's boards (LSCBs). (Children Act 2004 (Director of Children's Services) Appointed Day Order 2007 (SI 2007/1792)

The current *Protocol for Judicial Case Management in Public Law Children Act Cases* [2003] 2 FLR 719 will be replaced by the Public Law Outline (PLO) from April 2008.
From 1 July 2007 breach of a non-molestation order became a criminal offence. Since it carries up to 5 years imprisonment it automatically becomes an arrestable offence (without warrant). (Domestic Violence, Crime & Victims Act 2004 (Commencement No 9 & Transitional Provisions) Order 2007 (SI 2007/1845))

When an 8-year-old was placed in foster care following physical abuse by her mother, the High Court allowed the local authority to disclose the facts to the mother's employer when she started working with vulnerable adults. The judge was explicit that the care of vulnerable adults equated with the care of children, and the standards should be the same even if the skills required might be different. (A *Local Authority v K* [2007] EWHC 1250 (Fam))

News Digest

Ollie Bridewell
Superbike rider Ollie Bridewell, 21, died from head injuries during practice for the Bennetts British Superbike Championship at Mallory Park, Leicestershire on 20 July. His father and younger brother Tommy, who also rides for NB Suzuki, were at the trackside.

Charlotte Gainsbourg
The French actress Charlotte Gainsbourg, 36, had surgery for a brain haemorrhage on 5 September. She had experienced several weeks of headaches after a waterskiing accident in the USA.

Anita Roddick
Body Shop founder Anita Roddick, 64, died from a brain haemorrhage on 10 September. In 2004 she had been diagnosed with hepatitis C, contracted from a transfusion when giving birth to her daughter in 1971, which caused cirrhosis.

Tiny brain, normal life
The Lancet reported the case of a 44 year old Marseillais civil servant who presented at l'hôpital de la Timone in 2003, with pain in his left leg on walking. Dr Lionel Feuillet, the neurologist who also teaches at l'Université de la Mediterranée, found in his notes the man had had a shunt fitted for hydrocephalus from ages 6 months to 14 years, but MRI revealed a huge 'black hole' where there was enormous hypertrophy of lateral ventricles and his grey and white matter were squashed against the cranial walls. Dr Feuillet would expect such results in someone 'bedridden and demented'. The man's IQ tested at 75, he was married with two children and gave no concerns in social functioning. (*The Lancet* **370**(9583) 21 July 'Tiny brain, normal life'; Sophie Manelli, La Provence 20 July)

Memories
The *Journal of Neuroscience* published research by the University of California, Irvine, showing the formation of a memory in the brain. When a rat learned to navigate a maze the process consisted of 10,000 changes in its synapses. One test group was allowed half an hour to learn their way around, a second group was given a drug known to block memory formation, while a third was the control. Fluorescent antibodies highlighted nerve connections that had been strengthened. The new technique is called restorative deconvolution microscopy. The study vindicates the cellular basis of memories proposed by Theodore Ribot's *Diseases of Memory* in the 19th century, via our old friends Tolman & Honzik's rat maze and cognitive mapping.
http://www.uci.edu

Deep brain stimulation
The Cleveland Clinic Ohio reported on successful trial of deep brain stimulation (DBS) in a 38 year old man who was minimally conscious for six years. Neurosurgery professor Ali Rezai had pioneered the technique in 2005 on a man brain injured in an assault six years earlier. The latest patient can now eat and sleep, and was even able to recite the first sixteen words of the Pledge of Allegiance. The team will now begin a formal trial on 12 American patients.

Drivers' probation
The government will publish a consultation paper this autumn on whether a 12 month training period should be introduced for new car drivers, in effect preventing 17 year olds from holding a full licence. DfT research suggests this would prevent 1000 deaths and 7000 serious injuries a year.

DC-Vax
On 9 July NorthWest Biotherapeutics issued a press release titled 'World's first therapeutic vaccine for brain cancer commercially available to patients in Switzerland'. Immediately its share price rose over 150%. On 16 July it issued a clarification that the Swiss Institute of Public Health had not yet reviewed the safety or efficacy of DC-Vax. Its shares fell. Class action lawsuits have been filed in the USA alleging that investors were misled, and even that some directors had deliberately leaked the story to artificially inflate shares.

HD
The *Journal of Neuroscience* (22 August) published Leeds University and others' research into Huntington's disease, with the prospect that the cancer drug trichostatin c may be developed to slow or even stop its progression. (Leeds Institute of Molecular Medicine (LIMM))

OBE
Science published two studies of out-of-body experiences (OBEs) that recreated them in the laboratory and indicate the brain can be misled by circuits not working properly. UCL and Ecole Polytechnique Fédérale at Lausanne separately used virtual reality goggles and tactile stimulation.

and finally...

Knowing your onions
Resarchers at Hokkaido Tokai University in Japan found that onions contain a sulphur antioxidant which flushes toxins from the body and speculated that eating them may help prevent memory loss in dementia and other conditions.

2012
Twenty-two epileptic seizures were reported as a result of the London 2012 Olympics logo being screened by the BBC without risk assessment, Ofcom ruled.

Baby you can drive my car
Robert Hanson, 48, was ordered by Derby Crown Court to attend parenting classes after letting his 10 year old visually impaired and autistic son drive the car Mrs Hanson was given in a mobility scheme. He admitted dangerous driving, no licence or insurance. He said he had been letting the boy drive on public roads to 'calm him down'.

Advertising

Rates

Non-BABICM training events remain unchanged.

Commercial and Recruitment:

Quarter page	£150
Half page	£240
Full page	£400

Courses and Conferences:

Quarter page	£75
Half page	£120
Full page	£200

Enquiries regarding advertising should be made to the BABICM administrator.

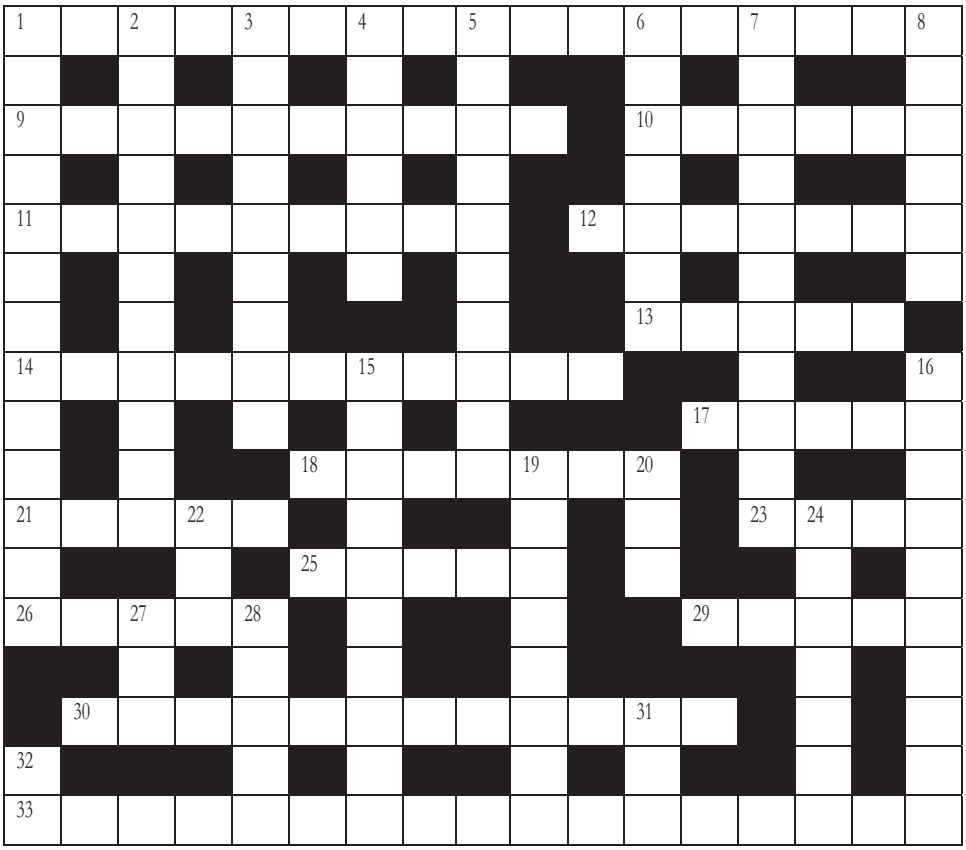
Please note that the Council reserves the right to decline any advertisement which it considers unsuitable.

Crossword

Newsletter 35 / *answers*

C	H	A	M	P	I	O	N	S	H	I	P	■	Q	■	■	■
A	■	■	■	O	■	■	A	■	U	■	R	■	U	■	U	■
D	E	V	E	L	O	P	I	N	G	■	O	R	A	N	G	E
E	■	E	■	Y	■	■	L	■	■	■	N	■	N	■	A	■
T	A	N	G	E	N	T	■	■	L	■	T	■	G	■	L	■
S	■	E	■	L	■	■	B	■	I	S	O	T	O	N	I	C
C	Y	P	H	E	R	P	U	N	K	■	■	■	■	A	■	O
H	■	U	■	C	■	■	C	■	E	■	■	■	E	C	R	U
E	■	N	■	T	■	S	K	E	W	E	R	■	■	R	■	N
M	A	C	E	R	■	■	R	■	I	■	■	C	H	E	A	T
E	■	T	■	O	■	H	A	R	S	H	■	L	■	■	■	R
■	■	U	■	L	■	■	M	■	E	■	■	A	L	I	B	I
C	U	R	R	Y	■	C	■	I	■	L	■	D	■	R	■	E
H	■	E	■	T	■	R	■	S	■	O	■	D	■	I	■	S
U	■	■	■	E	■	A	S	S	O	C	I	A	T	E	D	■
M	■	■	■	■	■	Z	■	U	■	A	■	G	■	■	■	■
P	R	I	M	A	R	Y	H	E	A	L	T	H	C	A	R	E

Newsletter 36 / *clues*



Across

1, 33. Spokespersons for incompetent clients (11,6,8,9)
9. Single issue vote (10)
10. Charity figurehead (6)
11. Instigator of fear in crime or politics (9)
12. Monitor and adjust drug levels (7)
13. Labour camp (5)
14. Hands and feet (11)
17. Buddhist Indian Emperor (5)
18. Diagnostic machine (7)
21. Protruberance (5)
23. Agreement or distribution (4)
25. CSF drain (5)
26. A woman taught Frank Ifield to do it (5)
29. Something wrong with singular girl (5)
30. Painted lady from Babylon to Jezebel (7,5)
33. See 1ac

Down

1. Past saving (13)
2. Respectful (11)
3. Staff (9)
4. Short and enzyme free (3,3)
5. Belch (10)
6. Associating one set's elements with another's (7)
7. Adopted as citizen (11)
8. Surgical blade (6)
15. Incomprehensible (10)
16. Study of projectiles (10)
19. (Say) nothing (3,1,4)
20. Eye cell for dim light (3)
22. Go (horse) (3)
24. One of select few (7)
27. Familiar medic or computer item (3)
28. Emotive verse (5)
31. Earlier (3)
32. 4840 square yards for short (2)