

EXPERT MEDICAL REPORT FOR THE COURT

prepared by:

Mr Daniel Lewis

MB BCh MRCS FRCSEd (Tr &Orth.)

Consultant in Trauma & Orthopaedics
Spire Cardiff Hospital, Croescadarn Road, Pentwyn
Cardiff, CF23 8XL

Date of Report: 13/12/2013

Claimant: Miss X

Date of Birth: xx/xx/xxxx

Address: xxxx

Date of accident: 16/07/2013

Place of Examination: West Quay Medical Centre, Barry

Date of Examination: 04/12/2013

PREPARED AT THE REQUEST OF:

ALP Alps Legal Services Ltd
Sunnyside Mill, Highfield Road, CONGLETON, Cheshire CW12 3AQ

Our Ref: xxx

Your Ref: xxx

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1. ABRIDGED CURRICULUM VITAE

CURRENT POSITIONS

Consultant in Trauma and Orthopaedic Surgery, Royal Glamorgan Hospital
(Specialist Interest in knee and Sports surgery)

Cardiff Sports Orthopaedics LLP - Partner

PROFESSIONAL QUALIFICATIONS

FRCSEd (Tr & Orth), Royal College of Surgeons of Edinburgh (2010)
MB BCh, University of Wales College of Medicine, Cardiff (2000)

EDUCATION

Ysgol Glantaf, Cardiff (1988-1993)
St Cyres School, Penarth (1993-1995)
University of Wales College of Medicine(1995-2000)

MEMBERSHIP OF PROFESSIONAL BODIES

General Medical Council (4746339)
British Orthopaedic Association (BOA)
Royal College of Surgeons of Edinburgh
British Association for Surgery of the Knee (BASK)

TEACHING / EXAMINATION

I am actively involved in teaching medical students and am also a trainer for orthopaedic registrars. I am on the faculty at WIMAT for a variety of trauma and orthopaedic courses.

2. INSTRUCTIONS

To provide a report based on history of examination of claimant.

3. ISSUES

Injuries Sustained:

1. Soft tissue injury to neck and upper back commonly called whiplash
2. Soft tissue injury to left knee

4. DOCUMENTATION

Documentation Supplied:

Record	Supplied (Y/N)	Dates (From-To)
Hospital Records	N	
GP Records	N	
Physiotherapy Records	N	
X-Rays	N	
MRI	N	
Other	N	

Identification of Claimant:

UK Driving Licence

Attendees:

Claimant alone

5. HISTORY AS GIVEN BY THE CLAIMANT

Occupation:

- i. Charity Worker at a Hostel in Barry
- ii. Retail assistant in a large department store

Hand Dominance:

Right

History of Accident:

Miss X states that on the 16th July 2012 she was the front seat passenger in a car being driven by her mother. Her sister was in the back of the car. All passengers were wearing seatbelts. Miss X states that they were stationary in the car at the bottom of a hill at a junction. They were waiting to turn left. She tells me that the car was struck from behind by another car. Following the impact all passengers were able to get out of the car.

Miss X tells me that over the next few hours she began to develop neck and upper back pain. Over the following hours she also began to develop pains in her left knee.

Initial Treatment and Subsequent Progress:

On the day of the accident (16/07/2012) Miss X tells me that later that evening she attended her local Accident & Emergency Department. She was examined by the hospital doctor. No x-rays were taken. She was prescribed oral painkillers and was discharged home. Later that evening the pains in her neck and back increased and the pains began to radiate down to her shoulders. She also developed a headache. She also describes pain in her left knee which came on during the hours following the accident. She does not recall any pains radiating down her arms, or any associated loss of feeling or weakness.

Miss X tells me the pains in her shoulders lasted for some weeks but resolved of their own accord. Her left knee pain lasted several months but again improved without any further treatment.

Miss X tells me that she consulted her solicitor due to ongoing neck and general back pain. She was referred for a course of physiotherapy and to date has had approximately 10 sessions. Her physiotherapy treatment has now completed.

Current Status:

Miss X tells me that her neck pain is now much improved. She is asymptomatic from the point of view of her knee. She does describe some ongoing upper back pain which is exacerbated by increased physical activity. These pains can occur in work, particularly when she is lifting or bending. Miss X tells me that these pains do not limit her significantly with her day to day activities. She has now completed her course of physiotherapy and is not undergoing any further medical treatment or investigations.

Past Medical History:

Miss X tells me that she had some back problems as a child. She believed this to be a curvature of the spine. She was under hospital follow up as a child but has received no further treatment or medical input for many years relating to this. There is no other significant past medical history.

Psychological Disturbance:

Miss X tells me that initially she was a little anxious about returning to driving but is now doing so without any significant problems.

Social History:

Miss X is a non smoker and a social drinker. She is not married and has no children.

Loss of Amenity:

- **Work life:** Miss X continues to have 2 different employments. She describes some ongoing back pain when she is stacking shelves or bending, but is able to carry out her employment requirements.
- **Social life:** Miss X used to enjoy attending the gym on a regular basis. She was unable to do this for several months following the accident but is now able to do this without problems. She has returned to all other social activities as she wishes.
- **Domestic life:** Miss X tells me that initially following the accident she struggled with elements of housework which required heavy lifting. She is now able to carry out all activities of daily living without problems.

6. EXAMINATION OF THE CLAIMANT

Miss X walked comfortably into the examination area and sat comfortably on a chair during the course of the history taking. She got on and off the examination couch without any obvious difficulties.

On examination she had a full range of normal, pain free movement in both hips and knees.

She had a full range of pain free movement of her neck, thoracic and lumbar spine. No bony midline tenderness along the spine. No abnormal upper limb neurology. Full range of pain free movements in both shoulders.

Clinical examination was essentially normal.

7. OPINION AND PROGNOSIS

Miss X is a 22 year old right hand dominant charity and retail worker who works in a large department store. On the 16th July 2012 she suffered personal injury when she was involved in a road traffic accident.

The mechanism of injury described to me is consistent with a rear impact while seated in a stationary car.

The symptoms described to me since the accident are consistent with

1. Soft tissue injury to the neck and upper back commonly known as whiplash.
2. Soft tissue injury to left knee.

Miss X's left knee symptoms seem to have resolved in the months following injury with analgesia and physiotherapy.

Miss X describes some ongoing symptoms in her upper back. These do not appear to be limiting her significantly in her day to day activities. I believe her symptoms may last for 12 – 18 months following injury but would be expected to resolve completely with time.

8. RECOMMENDATIONS

I do not believe that any further medical investigations or input is required. If Miss X did have exacerbation of previous symptoms then she may benefit from a further course of physiotherapy.

9. DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.
11. That I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
12. That I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
13. That I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to either of the above two points.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I confirm that I am aware of the requirements of CPR Part 35 and PD35, the protocol for the instruction of experts to give evidence in civil claims (supplementing PD 35 para 13.5) and the PD on pre-action conduct and confirm that I have complied with them.

I confirm that I have verified with the claimant the facts as referred to in this report.



Signed:

Mr Daniel Lewis

Consultant Orthopaedic Surgeon