

MEDICAL REPORT

J. B. WILLIAMSON, M.B.,Ch.B.,F.R.C.S.

Consultant in Spinal Surgery

Spire Manchester Hospital, Whalley Range, Manchester, M16 8AJ

Tel: 0161 232 2552 Fax 0161 232 2329 Email: sec@manchesterspine.co.uk

NAME: Joe Bloggs

ADDRESS: 47 Sydney Street
Whitley
Anytown
X1 7AT

DATE OF BIRTH: 17/10/1967

DATE OF ACCIDENT: 10/05/2012

DATE OF EXAMINATION: 27/08/2015

DATE OF REPORT: 08/03/2016

OCCUPATION: Unemployed

INSTRUCTIONS RECEIVED FROM: Any Solicitors LLP
Litigation Place
50 Sue Street
Anytown
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Ref: PMT/PMT/138947590

INTRODUCTION

5 I was appointed in 1991 to the post of Senior Lecturer in Orthopaedic Surgery in the University of Manchester with a special interest in Spinal Surgery. I trained in Spinal Surgery in Manchester and in Hong Kong. In 1995 I left the University to become a full time National Health Service Consultant in Spinal Surgery.

10 I was a full time NHS consultant until 2015. Between 2011 and 2015 I was the Chair of the Division of Neurosciences & Renal Medicine at Salford Royal NHSFT. As well as having a busy clinical practice in spinal surgery I managed (amongst others) thirty surgeons performing almost 5000 procedures each year.

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Since leaving Salford Royal I have remained active in both NHS and private clinical practice.

HISTORY

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I saw Mr. Bloggs at the Spire Manchester Hospital having received instructions from Any Solicitors to prepare a report in connection with an action for personal injury arising out of a fall on the 10th May 2012.

25 In my possession were the following documents:

- General Practitioner's records
- Wythenshawe (UHSM) records
- Salford Royal Hospital records
- Pennine Acute Hospital records

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- Employment Support Allowance records
- Disability Living Allowance records
- Industrial Injury Disablement Benefit records
- Compensation Recovery Unit records
- DWP Clerical Records

- 35
- Claimant's Expert Evidence:
 - Mr George T Insane
 - Mr Ivan T Terrible
 - Dr I Feelgood
 - Dr IST Sheriff
- 40
- Mr R Amundsen
 - Mr Z Stardust
 - Professor Gnosa Lott
- Pleadings:
 - Defence
- 45
- Reply to Defence

Mr. Bloggs tells me that on the date in question he was working as a chauffeur. He was asked to go on the roof of his employer's bungalow and clear off some moss. He was working on the roof, with one foot on a set of ladders, when the ladders slipped. Mr. Bloggs fell to the floor. He caught his right arm on some lead flashing as he fell. He landed on his feet and heels and then fell flat on his bottom.

The gardener took Mr. Bloggs to Wythenshawe Hospital Accident & Emergency Department. At that time the main concern was his cut arm. His arm was sutured under local anaesthetic. He tells me that a huge haematoma developed. Mr. Bloggs had severe pain in his arm, but was also aware of backache at that time.

60 He took Tramadol for the pain in his arm. He had continuing treatment to his arm, which he describes as "a few operations."

His back continued to hurt from the fall and he subsequently attended North Manchester General Hospital Accident & Emergency Department and had an x-ray taken.

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Mr. Bloggs tells me that his leg pain started roughly five weeks after the fall. The pain was mainly in his left leg, although he did have some mild pain in the right leg. His leg pain was mainly in the left calf and buttock.

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He subsequently developed bladder and bowel symptoms. When he did he went to the hospital in Salford on the same day. He was admitted and had surgery on the same day. He was an in-patient for about a week. He was discharged from care in Salford about six months ago.

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EMPLOYMENT HISTORY

Mr. Bloggs had worked for his employer for around six months at the time of the fall. He has not worked since.

80

He was previously employed as an MOT tester, a mechanic and a doorman.

PREVIOUS MEDICAL HISTORY

85 Mr. Bloggs had a disc removed from his back about ten years ago. He tells me that he got better afterwards and described his state as "brilliant".

Notwithstanding this he did have backache and occasional sciatica since. He described these symptoms as "nothing major."

90

He has had other orthopaedic trauma in the past and describes pins and needles in his hands from a motorcycle accident some time ago.

PRESENT SITUATION

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Mr. Bloggs tells me that he has been recovering really well from his problems, but had suffered an exacerbation for the few days prior to our interview.

100 He has no back pain. He still suffers from leg pain. This pain is mainly on the left but to a lesser degree is also on the right. He has two different pains

which have a similar distribution. Pain radiates from the cheek of his buttock and down the outside of his thigh onto his calf and then to the top of his foot. He described some numbness in the same distribution, but no pins and needles. The first pain he experiences is a burning pain. This is constant and
105 is always there. He seldom has this in the right leg.

The other pain which he suffers is more aching and chronic in its nature and although it has reappeared over the past few days, prior to that he had not had any significant pain for two months.

110

Mr. Bloggs tells me that his bladder has “come back” recently. He has always had a normal desire to void, but previously has not been able to do so. He is now able to do so. Until recently he used intermittent self-catheterisation to manage his bladder.

115

He manages his bowels by daily irrigation. He has no feeling of desire to void and no anal tone. He soils himself occasionally but is usually clean if he manages his diet. He uses no laxatives.

120 Mr. Bloggs has no sexual feeling or function. He has not tried Viagra.

He has a drop foot on the left which has not recovered. He trips because of this on occasion, but stumbles more often. He tells me that he will fall to the floor four or five times a week. He says that this is not a drastic thing. He feels
125 that his stumbles are partly because the sensation in his foot is defective.

Mr. Bloggs takes regular Amitriptyline, Gabapentin, Paracetamol and Citalopram for his symptoms.

130 **EXAMINATION**

On examination Mr. Bloggs was able to dress and undress himself without assistance, although he did struggle to get his socks off and on.

135 He stood with a slight lumbar scoliosis. There was a greatly reduced range of movement in the lumbar spine and what was available was jerky and dyskinetic.

140 There was a 7cm low lumbar mid-line scar. There were many other small, superficial scars on his trunk and arms.

145 His balance was too poor to stand on tiptoe or on his heels, but formal motor examination revealed grade 4/5 weakness of dorsiflexion on the left with grade 2/5 weakness of great toe extension. Hip abduction was grade 4/5 and the rest of the power in the left lower limb, and the right lower limb was normal.

150 There was numbness to light touch from the left L5 dermatome (the dorsum of the foot) over the back of the leg to the S4 dermatome. Sensation on the right side was normal.

There was quite obvious wasting of the left calf, which I measured at 1.5 cms. It looked more on observation.

155 Mr. Bloggs walked, but he did have a slightly unusual gait.

REVIEW OF MEDICAL RECORDS

160 Lloyd George cards in the General Practitioner's records date back to 1967. The first note of relevance is in a letter from Philip DC Zed, Physiotherapist. This is dated 07/07/93 and reads:

“PC: Pain in neck and low back
In RTA 25-06-93...12 hours later felt pain in lower back...”

165 Another letter from Mr Zed is in June 2000 (date obscured by hole punch):

“PC: Low back pain
Onset 2/52 ago. No obvious cause...”

170 There is a barely legible entry dated 19 May 2001 in which the words “back pain” and “x-ray” are discernible The x-ray is reported on 29/05/2001 by Dr MRC Surgeons:

“The L4/5 disc space is narrowed. The L5/S1 disc is not clearly demonstrated but I suspect that it is reduced in height. No bone destruction identified. Bone texture normal”

175

There is an entry on a computerised summary sheet, dated 01/07/2001:

“C/O – low back pain radiating down right leg”

On 29 September 2001:

180 “C/O – Low back pain would like to change hospital ref to PP...

There is a letter of referral to Mr. Armfield, Consultant Neurosurgeon dated 27.9.01. This reads:

185 “Thank you for seeing this 33 year old man who complained of low back pains radiating down his right leg and into the lower leg...”

On 18/10/2001 he was prescribed Vioxx and tramadol (a strong opiate pain killer) by the GP.

190 Mr. Armfield saw him on the 12th November 2001 and wrote on the 13th November 2001, reiterating a history of:

195 “Intermittent spasms of his para spinal muscles with low back pain radiating into the outer aspect of both calves. He has also described paraesthesia in the lateral aspect of the calf, radiating into the soles of both feet...”

Mr. Armfield thought it sensible for him to continue with physiotherapy, take some analgesia and said he would arrange an MRI scan on the NHS.

200 There is a letter indicating that he attended the Outpatient Department at Salford Royal Hospital on the 4th February 2002, giving a history of on onset

of back and leg symptoms after being crushed by a recovery truck. An MR scan was arranged. Mr. Armfield wrote on the 27th November 2002:

205 “Joe underwent his MR scan of the lumbar spine in October. This shows a right sided L4/5 disc bulge and also right-sided protrusion at L5/S1. He will be seen in my clinic to discuss his management in the light of any ongoing symptoms but it does appear as if the right L4/5 disc is the cause of his problems.”

210 Mr. Armfield wrote again on the 20th January 2003:

“... I have no doubts that he is still in pain, despite Tramadol and Vioxx that he will benefit from surgical decompression and I am organising his name to be placed on the waiting list and will get him in for fenestration and discectomy bilaterally at L4/5 level...”

215

There is a discharge summary dated 12th September 2003 indicating that the procedure was performed uneventfully.

220 He seems to have made a good recovery from his surgery. There is a letter from Mr Armfield, abstracted in the GP records, dated 02/02/2004:

“His pains in the legs have disappeared, and he only occasionally gets pain in the back...He has been back to work and day to day activities...”

225 He attended again on 25/03/2004 and 29/06/2006 complaining of low back pain.

In the summary there is an entry in 2007 referring to:

“Acute back pain unspecified.”

230

A further entry on 22/08/2008 refers to:

“Low back pain.”

235 There is a letter from Alison Blackburn, Advanced Physiotherapy Practitioner to the General Practitioner dated the 31st October 2008. This reads:

240 “This gentleman presented with an 8 weeks’ history of acute central back pain caused when he had an injury at work. A lorry was coming towards him and going to squash him between a car and he was pushing against the lorry to try and avoid being crushed. Since then he has had severe central low back pain slightly to the right hand side but no peripheral symptoms...”

There is a record of Mr. Bloggs’s attendance in the Emergency Department at the University Hospital of South Manchester on the 10th May 2012 at 11.34. The triage diagnosis is:

“Trauma right lower arm... Slipped onto metal.”

His pain score on triage was noted to be:

250 “obs [?objective] 6 sub [?subjective] 6”

There is a handwritten clerking by the Emergency doctor. A past medical history of back problems is noted, but there is no other comment about contemporary back problems. The wound on his arm was cleaned and dressed.

He re-attended on 16.5.2012 when the presenting complaint was given as:

“Haematoma right forearm.”

260 On this occasion his pain score was said to be:

“obs 2 sub 2”

and he declined pain killing drugs.

265 He was seen by the A and E doctor, Orthopaedic on call doctor, and the Plastic Surgery on call doctor. None noted back problems.

In the surgical safety check list dated the 16th May 2012 there is an entry which reads:

270 “Factors affecting positioning. Has ongoing back problem. No positional problem identified.”

A UHSM physiotherapy note dated 19/5/12 talks about his peripheral nerve lesion, and continues:

275 “PMH: nil”

In the pre-operative clerking dated 21st May 2012 there are annotations indicating that he took Tramadol prn and Diclofenac prn for back pain.

280 At 07:34 on 25/06/12 he attended the Accident and Emergency Department at North Manchester General Hospital. His complaint at triage was:

 “Back pain”

and his pain score was given as 10.

285 He was seen at 08:15 by Dr J Piggott (FY2) who noted:

 “PC – Back pain

 HPC= fell off a roof 6 weeks ago onto feet. ↑ pain in lower back since.

 Lifting tyres 3 days ago - unable to walk due to back pain since then.

 Has also noticed decreased sensation to calf and left foot. No bowel or

290 urinary incontinence. Denies any saddle anaesthesia...”

He was x-rayed and allowed home, with his GP to arrange physiotherapy.

295 He then presented at the Accident and Emergency Department at Salford Royal at 16.42 on 27/6/2012. The Triage note reads:

 “severe low back pain, longstanding problem, sudden onset 2 days ago neurological symptoms...”

300 He was seen by Dr J Old (FY2) at 18.40, who recorded:

“4/52 ago fell 1 story [sic] onto heels. Jarred his back. X-ray at Crumpsall – NAD. Last 2 days developed neurology. Cannot feel his perineum/testicles...

305 Rt ankle – bruised and swollen over rt lateral malleolus [the remainder of this annotation is amputated because the page is not completely photocopied].

An x-ray of the ankle and a magnetic resonance scan of the lumbar spine was arranged.

310

The ankle x-ray was reported by Sam Bywater SPR at 19:33:

“Clinical History: cauda equina. Loss of sensation in right ankle. Very bruised and swollen. Patient unaware if painful or not. ? fracture”

315 No fracture was seen.

The MR Scan was reported at 23.08, the radiologist concluding:

“Complete effacement of the spinal canal due to a large disc extrusion at L4/5...”

320

There is an addendum at 23.10:

“There is cauda equina compression at L4/5. Given the patients symptoms, an urgent neurosurgical opinion is advised.”

325 The admission clerking, at 01.04 on 28/06/2012 notes:

“Slid from a ladder and landed on his heels nearly 6 weeks ago. Since then he has noticed back pain and left sided sciatica... He denies any progression in either of the symptoms in the last 48 hours...NO [original emphasis] further trauma...”

330

However, a Nursing Evaluation at 02.58 on 28/06/2012 records:

“...Joe noticed a change in neurology over last two days...”

There is an operation note which records an uneventful
335 “Redo Lumbosacral L4S1 Laminectomy, Microdiscectomy, Rhizolysis”
performed by C Chow.

Annotations and correspondence in the Salford Royal records record an
uneventful recovery from his surgery. Because of a high bladder residual
340 volume after voiding he was referred to urology and taught to self-catheterise
in July 2012.

A follow-up MR scan in September 2012 showed good decompression of the
cauda equina.

345
There is a letter from Mr. C. G. Plum, Consultant Plastic Reconstructive and
Hand Surgeon at the University Hospital of South Manchester dated 22nd
October 2012. He states:

350 “... He had a cut on his right forearm and this was repaired, but he is
suffering significant problems related to his hand. He has a dystonic
series of movements and I am not sure whether these are learned
movements in compensation for a problem, or whether they are a
genuine physiological phenomenon. Either way they are producing a
non-functional right arm and therefore I have asked him to see our
355 hand therapists for consideration of exercises to improve dystonic
movements, and mirror box therapy...”

There is a letter from Mr. H. Pathak, Consultant Neurosurgeon dated 20th
November 2012 which gives a diagnosis as follows:

360 “Cauda equina syndrome.
Continuing problems with incomplete bladder emptying.
Left leg weakness and left leg pain.”

Mr. Pathak continued:
365 “For my part I am going to discuss his case with a colleague of mine to
whether repeat discectomy and fusion might be of benefit here...”

Mr. Pathak wrote again on 12.12.12:

370 “... One of the issues that we could try is to block the nerve on the left side to see if we can get you better pain relief. I will bring you back to clinic to re-assess you with regards to this.”

He wrote again on 19.2.2012:

375 “...I am reluctant to offer a third time operation without having any objective evidence where the pain is coming from. In trying to find this and following discussion with one of my spinal colleagues, we thought it would be prudent to block the root on the left as it exits out the foramina. If this is successful then we would have a target and then I will re-discuss with my spinal surgical colleagues about surgical
380 decompression and potential fixation at that level.”

There is a claim form for Industrial Injuries Disablement Benefit (IIDB), dated 30/7/2013, in which Mr Bloggs recounts the index event:

385 “I was up an unsupported ladder cleaning the gutters when the ladder slipped and I fell to the ground”

He goes on to describe his neurological status as:

“partially paraplegic”.

390 There is an IIDB assessment advice, dated 01 Oct 2013. Dr C Meek records the Customer’s statement as follows:

395 “the ladder broke and I fell down from the roof the the [sic] ground, injuring my right arm and back...Overnight at home I felt my bladder was full but cd not pass urine...About 3 weeks after this a physiotherapy friend suspected a back problem so I was taken to Salford. Scan done and I was taken to theatre right away...From the very beginning I had a catheter in even when I was sent home...”

400 Mr Bloggs's solicitors wrote to the General Practitioner on 5 December 2013, giving an account of the index event:

405 "...Joe had to climb a leaning ladder and step onto the roof to carry out what he had been asked. He kept his right leg on the ladder and stretched his left leg out onto the roof. Whilst he reached forward the ladder slipped from underneath him, causing him to slip forwards making him fall onto the roof. He had no opportunity to grab onto anything as he found himself slipping down the roof and as he did so he caught his right arm on the metal flashing of the chimney pot which slashed through the skin. As he fell from the roof the heels of his feet
410 landed hard on the floor on the flagstones which then caused him to fall backwards onto his back."

There is a letter from Dr. Peck in the Pain Clinic at North Manchester General Hospital dated the 10th April 2014. He writes:

415 "... He says that he had very good benefit from the last injection that I carried out for his left sided sciatica, but is still having problems with the dead feeling in his leg and his back pain. In view of this I would be grateful if you would give him a trial of Butrans patches..."

420 There is a referral to physiotherapy dated 17.6.2014 which says:

425 "...The outcome of his spinal surgery was relatively poor and he has been left with quite significant lower limb neurological impairment in terms of markedly weak left lower limb with marked foot drop and wasting and also weak right lower limb, with marked sensory disturbance in both with some sensory blunting. He also has bladder issues and currently self-catheterises several times a day and also has to undergo self-administered anal irrigation for his bowel problems. He also has some functional problems and some pain in his right upper limb and is currently under the pain services under Dr. Gregory. He
430 tells me that he did have a crutch to aid with his mobility but this has now been lost/stolen..."

There is a letter dated the 17th June 2014 from the General Practitioner, Dr. P Le Fylde, to Smith Jones Solicitors. He writes:

435 "... I have referred him through to the physiotherapy services which will be based up at Fairfield General Hospital for an assessment from them, in terms of his mobility and also to assess some of his fall risks and the need for physiotherapy input.

I have referred him through to the occupational therapy service at Bury
440 for an OT assessment...

I have written to Social Services asking them to contact him to make an assessment of his care needs and any input they can give.

I have initiated a referral through to primary mental health care services to look at psychological interventions...

445 Unfortunately, his notes appear incomplete and we did not receive a full set of hard copy correspondence from previous GPs despite the efforts of NHS England and the PCSS Manchester to try and obtain these. We do appear to have some electronically derived copies of correspondence but his notes are by no means complete..."

450

There is a letter of referral dated 17.6.2014 from the General Practitioner to the Adult Mental Health Services stating:

"... he does admit that he now feels really quite flat, down, and frustrated with the ongoing saga of the above..."

455

There is a similar letter of the same date to Occupational Therapy and one dated 31st July 2014 to the Pain Clinic.

There is an Occupational Therapy report, from Pennine Care NHS foundation
460 trust, dated 14/8/14. Julie Less records:

"Mobility

Client is variable from day today. Mobile using two crutches when having good day, if he is having bad day has to self-propel himself in his wheelchair."

465

There is a letter dated 7.11.14 to the General Practitioner from the Community Occupational Therapy Service. A number of problems are identified and the treatment provided is detailed as:

470 “Provided with information on strategies to help client with sleeping.
Client declined occupational therapy treatment to help him with his
memory. Client declined bath lift that was recommended and declined
to be taught relaxation techniques. Client did not provide written
permission off his land/lord or lady as requested for fitting grab rails
outside his front door, therefore these could not be fitted. Advised
475 where to purchase locally aids to assist him with domestic activities
and purchase tray for his wheelchair so he can transport items.”

There is an entry in the GP records dated 5.12.2014 which reads:

480 “Patient reviewed. Finally came in issues discussed and covered.
1. Had been to urologists Salford, states had USS as per letter and
told scan ok no kidney damage. No bloods done so arrange here.
2. Was seen by via IAPTS states didn't feel comfortable with person
seen was “challenged” DNA further appts. Discuss feels should engage
given card for healthy minds for self-referral in. Encouraged to do so.
485 3. Discuss letter Dr. Peck. Initially states taking gabapentin pointed out
no scrips from us for some time states has supply at home but then
admits only takes PRN. Discuss options and how to take and
expectations. Agree will discard meds safely at home. Recommence
gabapentin 300mg one daily building to 300 tds over 10 days then see
490 new year. Poss titration up if tolerates consider duloxetine as alt. Note
has neurogenic bladder self-catheterises and ?amitriptyline best option.
3. States in contact with supplies CCG/CSU re catheters.
4. Continues to agree to contact with solicitors.
5. See OT report declined some of adaptations suggested.
495 6. Was sent pain clinic apt Salford ?arrange by spinal surgeon didn't
engage with process will recontact Mr. Patel re reorganising.
7. Review new year consider referral Floyd unit.”

500 On 3.2.15 the entry reads:

“Patient reviewed. Apologises for last missed appointment. States better in some respect re pain but feels switched off/detached on gabapentin. Note neurogenic bladder issues etc. Discuss options see Dr. Gregory last letter. Agree tail off gabapentin/citalopram over next 2 weeks. Introduce duloxetine in 1 week increasing dose after 2 weeks. See 4 weeks for review.”

On 3.3.15:

510 “States feels much brighter and with it on duloxetine, now off gabapentin and citalopram. Happy with this states pains still there feel ‘sharper’ at times but feels more manageable. To continue current dose and see one month...”

He attended the Accident and Emergency Department at North Manchester General Hospital on 25 August 2015. His complaint was of increased back pain. The A&E doctor records an examination as follows:

515 “↓ sensations dull ache but the back of left leg extending downwards (this is not new)

Normal motor power to toes ankles knees”

520

There is an Industrial Injuries Disablement Benefit renewal advice dated 02/11/2015. Mr Bloggs writes:

525 “I cannot pass urine and stool and still self catheterize. I still have a drop left foot and I still have constant pain in my right arm, hand and lower back... I walk very slowly with crutches and cannot walk more than 50 m... I cannot use stairs... I cannot sit or stand for long periods. I cannot bend down.... I struggle with shoes socks and buttons...”

530 **REVIEW OF RADIOLOGY**

I have not been provided with any imaging.

REVIEW OF MEDICAL EVIDENCE

535

Mr. G. T. Insane, Consultant Orthopaedic & Spinal Surgeon

Report dated 6th March 2013

Mr. Insane recites a history compatible with that given to me. It seems that Mr. Insane has seen the Salford Royal records. Interestingly, on examination Mr. Insane did not find any lower limb wasting. He did not think that he had seen all of the medical records but had no doubt that Mr. Bloggs sustained injuries in the index incident on the 10th May 2012 stating that he had injured his forearm and his lower back. However, the first entry which he has seen which mentions contemporary low back pain is dated 2.7.2012, almost two months after the index event.

545

Supplementary report dated 4th July 2013

This report follows Mr. Insane's review of further medical records and MRI scan. Mr. Insane now thought that he had seen all of the medical records. He states that previously he was not convinced of a clear chronological relationship between the index accident and the onset of low back and leg pain. However, he now says that having reviewed all the records and on the balance of probabilities, he believes that the recurrent disc prolapse was the result of the index accident. He does not say which particular piece of evidence has led him to this conclusion.

555

In his review of the medical records he quotes contradictory evidence:

“28.6.12 A&E Referral to Neurosurgery. Slid from a ladder and landed on his heels nearly 6 weeks ago. Since then he has noticed back pain and left sided sciatica. A week developed left leg numbness which worsened 2 days ago with numbness extending into the buttock and external genitalia...”

560

Comment: All this entry tells us is that the back pain and left sciatica started after the index event. I do not read it as necessarily indicating a direct chronological relationship.

565

570 “02.7.12 The discharge summary contains a similar annotation:
 “He had slid from a ladder and landed on his heels nearly
 6 weeks ago. Since then he has noticed back pain and
 left sided sciatica.”

Supplementary report dated 21st September 2013

575 This report follows a re-examination. Mr. Insane notes that Mr. Bloggs had
 made considerable progress since his previous assessment but continued to
 have significant problems. He thought he needed to continue with his further
 physiotherapy and recommended reports from various other specialists – a
 Urologist, a Neurophysiologist, a Gastroenterologist, a Psychologist and a
580 Pain Specialist.

 It seems that Mr Insane has not seen the records from North Manchester
 General Hospital, in particular the records relating to Mr Bloggs’s attendance
 on 25 June 2012, having injured his back lifting tyres, which preceded his
585 admission to Salford.

Mr. I. T. Terrible, Consultant Plastic Surgeon

Report dated 24th June 2013

590 Mr. Terrible’s report concerns the upper limb laceration. He said the scar
 would be permanent but the discolouration would fade. He thought the scar to
 be unsightly. He noted an area of sensory loss due to the damage to the
 cutaneous nerve which would be permanent.

Dr. I. Feelgood, Consultant Psychiatrist

595 Report dated 17th June 2014

 Dr Feelgood’s report contains an account of the index event (para 6.2), which
 presumably comes from the claimant’s account:

600 “Mr Jones instructed him to climb a ladder up to the roof of his
 bungalow and remove the moss from the roof. Mr Bloggs was dressed
 in a suit and not properly clothed to conduct this task. He climbed up
 the ladder, which extended up as far as the gutters, stood on top of the

605 ladder and started scraping moss off the roof. He felt the ladder slip from under his feet and he slid down the roof. There was nothing to grab as he fell off the roof. He somersaulted during the fall and landed on his heels. His feet and back were hurting immediately. He was mainly concerned about his right arm because he could hear a "gurgling sound" and blood was squirting out of his arm."

610 Dr. Feelgood considered that Mr. Bloggs met the criteria for an adjustment disorder with recurrent depression and a generalised anxiety disorder. He considered that both of these conditions were caused by the index event and its consequences. He noted a history of depression which indicated some vulnerability and suggested that Mr. Bloggs should be referred to a psychiatrist. He thought that a more definitive prognosis could be given once
615 he had had the chance to assess Mr. Bloggs's response to treatment.

Dr. I.S.T Sheriff, Consultant Clinical Neurophysiologist

Report dated 24th June 2014

This report takes the form of a report of neurophysiological tests. Dr. Sheriff
620 concluded that his study showed:

"... the presence of a right lateral antebrachial mono-neuropathy consistent with the history of traumatic division of this nerve..."

Mr. R. Amundsen, Consultant Neurosurgeon

625 Report dated 16.10.2014

Mr. Amundsen noted that Mr. Bloggs presented in Salford on the 27th June with a cauda equina syndrome. Mr. Amundsen considered that his L4/5 disc was vulnerable at the time of the injury on account of his pre-existing longstanding constitutional degenerative changes, present for many years. He
630 considered that in the absence of the index event Mr. Bloggs's lumbar spine condition resulted in a self-limiting recurrent attacks of low back pain, muscle spasm and stiffness which may have become more frequent and troublesome but would not have prevented him from continuing in employment up to the normal retirement age. He thought it most unlikely that Mr. Bloggs would have

635 suffered a recurrent disc prolapse and would not have required further surgery.

He goes on to hypothesise that the fall weakened annular fibres of the intervertebral disc. He thought that he would need to continue with self-catheterisation and would be vulnerable to repeated episodes of urinary infection. He thought his sexual dysfunction was permanent, as was his bowel and other neurological dysfunction.

He considered him to be genuinely and severely handicapped on account of his neurological dysfunction. He thought that he was handicapped in his ability to undertake physical tasks at home, and walk more than a short distance. He thought there was no further role for surgery.

It seems that Mr Amundsen has not seen the records from North Manchester General Hospital, in particular the records relating to Mr Bloggs's attendance on 25 June 2012, having injured his back lifting tyres, which preceded his admission to Salford.

Mr. Z. Stardust, Consultant Hand & Upper Limb Surgeon

655 Report dated 23rd February 2015

Mr. Stardust's report considers only the arm injury. He thought that Mr. Bloggs appeared to have developed a complex regional pain syndrome. He thought that his pain on the ulnar border of the forearm could only be explained by an ulnar nerve lesion which could be difficult to explain on the basis of a laceration. He noted that the neurophysiology did not support this diagnosis and he could not provide an "organic hand surgical explanation." He did not think that Mr. Bloggs's upper limb problems would prevent him from working or provide any other needs for care.

665 **Professor G.Lott, Professor of Pain Science**

Report dated 7.6.15

Professor Lott considered that Mr. Bloggs had neuropathic right forearm pain caused by a division to the right superficial antebrachial nerve. He did not find

670 any features of regional pain syndrome, and considered that the claw hand was a behavioural response to the painful symptoms. He thought there was a neuropathic element to his back pain as well as undoubted mechanical components. He considered that the description of the leg pains was suggestive of neuropathic pain.

675 Professor Lott reaches the conclusion that there probably was an injury to the back in the index event. He suggested that he be treated in a pain clinic and that injection based therapies may be helpful for the lower limb symptoms.

Supplementary Report dated 9.6.15

680 This report follows review of Mr. Amundsen's report.

OPINION

Causation

685 Mr. Bloggs suffered injuries on the 10th May 2012. He suffered a laceration to his forearm which has resulted in persisting problems. These problems have been the subject of reports from appropriate experts and lie outside my field of expertise.

690 After the index incident he developed low back problems. Mr. Bloggs has a long history of low back problems, pre-dating the index event. This history includes a previous surgical intervention. There are mentions in the Wythenshawe Hospital records of continuing back problems at the time his forearm problems were being treated. There is however no comprehensive
695 documentation linking an onset or worsening of back symptoms to the index event.

There are numerous, contradictory accounts of the events on 10 May 2012. Determining which of these accounts is to be preferred is a matter for the
700 Court, rather than expert opinion. However, my experience as an Orthopaedic Spinal Surgeon is that it would be unusual for a patient to fall from a height of 12 feet, landing on the heels, and suffer an injury to the spine without

suffering an injury to the heels (either an os calcis fracture, or at the least significant bruising), knees or hips. As there is no documentation of any such
705 injuries, it is my professional view that this mechanism is unlikely.

The mechanism of injury is relevant to the potential for spinal injury.

If the Court should decide that the mechanism of injury on 10 May 2012 was
710 such that it involved the claimant slipping or sliding to the ground, cutting his arm in so doing, then it is my view that a significant spinal injury is unlikely to have resulted. This would be in keeping with the version of events after the incident suggested by the medical records – that Mr Bloggs did not complain of back symptoms for a considerable time after the event. In these
715 circumstances, I would regard the development of Mr Bloggs's spinal problems, including his Cauda Equina Syndrome to be the result of his longstanding constitutional spinal problems.

On the other hand, if the Court should find that the events of 10 May involve a
720 mechanism likely to have expended a significant force on the spine – such as a fall from 12' onto the feet, followed by a fall to the buttocks or back, then it is possible that Mr Bloggs suffered a significant spinal injury. In order for this to be the case then Mr Bloggs would need to demonstrate a tight chronological relationship between the index event and the worsening of his constitutional
725 back symptoms.

It is my view that the medical records do not support such a relationship. Mr Bloggs saw a large number of doctors in the course of his treatment. There is no contemporaneous record of a complaint of increased back pain. The first
730 reference to back symptoms I have found (other than a note of a previous history of back problems) is the Surgical Checklist of 16 May 2012. Although others have read this as being evidence of back problems at that time, my interpretation is that this records that Mr Bloggs has a history of back problems, and therefore care was required during positioning for surgery.
735 There is an annotation in the preoperative clerking on 21 May referring to

taking tramadol and diclofenac for back problems, but I read that as being a historical observation, rather than something new.

740 The first annotation which unequivocally refers to a new spinal problem is the NMGH A&E entry, on 25 June 2012, which refers to the onset of symptoms after lifting tyres. It is clear that the situation changed at that point. I would observe that it is unlikely that a patient with significant acute back symptoms would be lifting tyres. Mr Bloggs did not tell any of his medical examiners of injuring his back lifting tyres.

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It has been suggested that Mr Bloggs was in such pain from his arm that this in effect “masked” the worsening of his back symptoms. Although I understand this phenomenon, and have seen it in both clinical and medicolegal practice, to account for late presentation of spinal injuries, I think 750 it is unlikely to have been the case for Mr Bloggs. I say this because one would not expect a sutured superficial wound to be very painful. There is no evidence in the records of severe arm pain. There is no record in the General Practice notes of requests for better analgesia. Indeed, when Mr Bloggs presented to the A&E Department on 16 May, his pain score was 2, and he 755 declined the offer of analgesia. When he was clerked by the Orthopaedic SHO on the same admission he is recorded as taking no drugs, so one can assume he did not require analgesia.

Notwithstanding the above, if the Court should find that Mr Bloggs did in fact 760 suffer a significant and lasting deterioration in his back condition, within a day or so of an incident with the propensity to cause a spinal injury, then it would be my view that the incident has adversely affected the natural history of Mr Bloggs’s constitutional spinal condition.

765 A disc prolapse is part of the spectrum of degenerative disease. The aetiology of degenerative disease of the spine is predominantly genetically determined, with a contribution from environmental factors. Such environmental factors predominantly include the amount of stress and strain put through the spine by an individual.

770

There is a range of views expressed by experts when asked to consider the question of the relationship between a traumatic incident and a disc prolapse. These views range from those at one extreme who say that any relationship between a traumatic event and a disc prolapse is entirely coincidental, and that the disc would have failed by herniation at that precise time notwithstanding the presence or absence of a traumatic event.

775

The other extreme is represented by those who say that in the absence of a traumatic event the disc prolapse would never have happened.

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To my mind neither of these extreme positions is supportable in the face of logical argument. It seems to me that a given amount of force is expended on the spine in a traumatic incident. This force is quantifiable but not easily measurable. If this amount of force is sufficient to cause the disc to herniate, then it strikes me as being sensible to suppose that whenever an equivalent amount of force has been expended on the spine in the course of the stresses and strains of the everyday life of that individual, then the disc would prolapse by herniation in any event.

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I believe it is reasonable in trying to come to a conclusion about the likely effect of the index event, if one considers the nature of the precipitating incident in terms of the amount of force likely to have been expended, which in Mr. Bloggs's case was significant but not catastrophic, and the extent of the pre-index incident history of back problems. In Mr. Bloggs's case there was a significant, longstanding history of back problems, including surgery. One must also consider the effects of the incident lifting tyres, which precipitated Mr Bloggs's attendance at NMGH A&E on 25 June 2012. It seems clear that this injury was more significant than any spinal injury Mr Bloggs may have suffered on May 10. I say this because the incident itself caused Mr Bloggs to attend A&E and complain of significant back symptoms, whereas on 10 May he did not mention back symptoms. On 10 May his pain score (whether due to arm pain, back pain, or a combination of the two) was 6. When he attended NMGH, his pain score due to back pain was 10. One could therefore

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805 reasonably regard the incident lifting tyres as a larger supervening event,
which could well have precipitated a prolapse in the absence of any injury on
May 10th.

810 Considering the effect of any spinal injury on 10 May (should the Court find
both that the mechanism of the index event was such that an injury was
possible, and that Mr Bloggs's symptoms worsened at the time of the index
event), then I believe that the effects of such an injury would be relatively
minor, when compared to the effects of the tyre lifting incident. One could
certainly say that the index event caused a transient worsening of the
815 claimant's symptoms between May 10 and June 22. Given the nature of the
subsequent tyre lifting incident, it is harder to draw conclusions about the
effect on the subsequent catastrophic disc prolapse, and cauda equina
syndrome. On balance, it would be difficult for me to understand how the
effects of any injury occurring as a result of the index event could be any more
than a 6-12 month acceleration.

820

Condition and Prognosis

As Mr Bloggs gives inconsistent accounts of his symptoms and disability. It is
difficult for a medical examiner to know what his present condition truly is.

825 When I saw Mr Bloggs, he told me of his problems, and I formed he
impression that he had made a substantial, but incomplete, recovery from his
problems. The contrast with what he wrote on his Industrial Injuries
Disablement Benefit statement in November 2015, just over two months after
our interview, is remarkable. On that form Mr Bloggs described a severe level
830 of disability. It is difficult to reconcile the two accounts.

I note that the Reply to the Defence deals with the issue of the ankle sprain
with which Mr Bloggs suffered at the time of his initial attendance at Salford
Royal. It is pleaded (para 12) that the claimant "went over" on his ankle when
835 transferring from bed to trolley in the MR unit. This cannot be the case for a
number of reasons. Firstly, I have worked at Salford Royal, and the hospital
has a very strong reporting culture. If a patient suffered such an injury in the

manner described, it is highly likely that the injury would have been the subject of an Adverse Incident Report (AIR). Secondly the ankle injury seems
840 to have preceded the MR scan by some time. The ankle problems are noted on the admission clerking at 18.40, leading to an x-ray of the ankle being taken at 19.33, and an MR scan later that evening. Therefore, it cannot be the case that Mr Bloggs injured his ankle in the MR scanner. This inconsistency in the history given makes it difficult for an examiner to have
845 confidence in Mr Bloggs's account.

On the basis of what Mr Bloggs told me, his leg pain, as others have said, meets the description of neuropathic leg pain. It may be that there are modalities available to treat this such as injection therapy or even spinal cord
850 stimulation, which would allow Mr. Bloggs to have a better functional outcome than he has at present.

Mr. Bloggs has a continuing level of neurological impairment in his lower limbs but this is not great. It is clear that he has recovered significantly since he was
855 examined by others. He has some weakness of great toe extension which can often cause the toe to be scuffed, but it is unusual for it to cause somebody to fall to the ground as frequently as the four or five times a week described by Mr. Bloggs, even when combined with his continuing sensory problems.

860 He is fortunate to have seen a recovery in his bladder function. He seems to have managed this himself and I suggested to him that he should seek a clinical (as opposed to medicolegal) urological review. Some patients who regain the capacity to void in these circumstances do so incompletely, leaving themselves vulnerable to complications.

865 He is fortunate in that his neuropathic bowel does not provide much in the way of a social handicap as long as he is attentive.

Mr. Bloggs is self-caring with respect to the normal activities of daily living. It
870 would not be unreasonable for him to require help with the heavier aspects of his household duties such as heavy lifting and gardening. He remains

unsuitable to ascend ladders and it would be difficult to imagine him returning to work as a chauffeur or any of the other jobs which he has known. He is however capable of light or semi-sedentary employment.

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For the avoidance of doubt, I would consider that these disabilities are the result of Mr Bloggs's constitutional spinal problems, accepting that these may have been brought forward by 6-12 months, depending on the Court's findings on the matters of fact discussed above.

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In summary therefore, it is my view that if the Court finds that the mechanism of the index event was such that an injury was possible, and that Mr Bloggs experienced a deterioration in his back symptoms from the time of the index event, then, bearing in mind the supervening injury which led to his attendance at NMGH A&E on 25 June 2012, the natural history of his spinal problems has been brought forward by 6-12 months.

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DECLARATION

890

I understand that my primary duty in the preparation of written evidence is to the Court rather than to the party who instructed me and have complied with that duty.

895

I am aware of the requirements of Part 35 and practice direction 35, the protocol for instructing experts to give evidence in civil claims and the practice direction on pre-action conduct.

900

The contents of this report and the opinions expressed are accurate to the best of my knowledge and belief and I believe that I have covered all of the issues which I have been asked to address.

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.

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The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

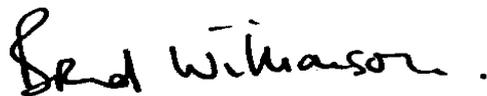
910 I have included those matters of which I have knowledge that might affect the validity of my opinion adversely.

I have not included anything in this report which has been suggested to me by others (and in particular my instructing solicitors) without forming an independent view.

915

I understand that my report will form the evidence to be given under oath or affirmation and its contents are true to the best of my knowledge and belief.

920 I have not entered into any arrangement where the amount or payment of my fee is dependent upon the outcome of the case.



925
J. B. WILLIAMSON
Consultant in Spinal Surgery