Mr. George Ampat
Consultant Orthopaedic & Spinal Surgeon

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ATTACHED ANONYMOUS REPORT AND JOINT REPORT

I have taken the liberty of attaching a Anonymous Report and the Joint Statement of a case that I have been involved in

This was a difficult and maybe a unique case of whiplash.

A 38 year old male was involved in a rear end collision.

He sustained soft tissue injuries to his neck.

He could not work following the accident.

The Orthopaedic surgeon who gave the first report on behalf of the claimant unfortunately died.

The report was challenged and there were Defendant reports.

There were 3 surveillance videos.

After nearly 6 years I was instructed. I examined and provided the report which is attached.

I then had a discussion with the Defendant's expert and prepared a joint statement.

The case finally concluded successfully.

It is a unique case which involves a lot of medical evidence and references.

This is a real case and I have used this case only to demonstrate the complexities involved even in a "simple" whiplash claim.

The test of a medical expert lies in backing and providing peer reviewed medical literature to support his / her argument. This case reasonably demonstrates that.

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MEDICAL REPORT PREPARED

FOR THE COURT ON

Mr XXXXXX XXXXXXXX

Photograph for identification

Dated 00/00/0000

Name	**Mr XXXXXX XXXXXXXX**
Date of Birth	**00/00/0000**
Date of accident	**00/00/0000**
Date of examination	**00/00/0000**
Address	**X, XXXX XXXXX**
	Xx, Xxxxxxxx, XX1 3XX
Your Ref	**12345678**
Solicitor Ref	**ABCD/123/EFG**

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10 pages of report

OPINION & SUMMARY

1. **This is a difficult case to provide an opinion.**
2. **There is no doubt that Mr. Xxxxxxxx injured his neck and lower back in the index accident on 08/04/2008.**
3. **Medical records show that he has had a brief history of low back pain in the past.**
4. **MRI Lumbar Spine performed on 00/00/0000 show that the L5/S1 disc demonstrates minor degenerative signal change, with a shallow posterior disc bulge causing mild bilateral L5 foraminal narrowing. There is no frank neural compression. I have not seen these scans.**
5. **In addition to the medical records there are numerous reports. I have attempted to summarise the reports below (Some details have been deleted for brevity and to maintain anonymity)**
    a. **00/00/0000 - Dr. Xxxxx - Neck pain will resolve in 12 months following the accident. The back pain requires MRI and Orthopaedic opinion.**
    b. **00/00/0000 - Report by Dr. Xxxxx Consultant Psychiatrist. In my opinion, the PTSD that he has developed was wholly and entirely the result of the road traffic accident that occurred on 8th April 2008.**
    c. **00/00/0000 - Report by Mr. Xxxxxx Orthopaedic Consultant. I would accept that an accident of this nature is likely to give rise to significant pain in his neck and back for a period of two to three months. I would then have expected gradual improvement and substantial recovery at a time nine months from the date of the accident. I would have accepted a period of time off work of three months because of the accident.**
    d. **00/00/0000 - Report by Dr. Xxxxx, Psychiatrist. In my opinion Mr. Xxxxxxxx was involved in an unpleasant road traffic accident, which may have met the first criteria for a diagnosis of post-traumatic stress disorder. Mr. Xxxxxxxx has had a complex reaction to this accident, with the effects of the accident being distorted and magnified by both his pre-existing vulnerability to depression and pain disorders and also the major changes in his family with the arrival of a new baby, but most importantly, I believe Mr Xxxxxxx presentation has been complicated by both alcohol use disorder and persistent cannabis use disorder.**
    e. **00/00/0000 Report by Mr. Xxxxx Orthopaedic Consultant - Having seen the videos, it is now my opinion, on the balance of probabilities that Mr Xxxxxxxx' professed disability at the time of my examination is due to**

conscious exaggeration and not due to any psychological cause. As noted in my report, I accepted that an accident of the type that Mr. Xxxxxxxx suffered was likely to give rise to significant pain his neck and back for a period of two to three months and I would then have expected gradual improvement and substantially recovery at a time nine months from the date of the accident.

f. 00/00/0000 - Report by Dr. Xxxxx, Psychiatrist. Having examined the surveillance and read the two reports of Mr Xxxxxxxx, if the Court accepts the opinion of Mr Xxxxxxxx, there is in my opinion no psychiatric explanation for the discrepancy between Mr Xxxxxxxx' reported disabilities and his observed disabilities as outlined in the supplementary report of Mr Xxxxxxxx.

6. **In addition to the records and reports I have also seen the three surveillance videos. The details of the surveillance videos are as detailed by Mr Xxxxxxxx in his report dated 00/00/0000. I completely agree with the account of the sequence of events seen in the video as stated by Mr Xxxxxxxx. The only conclusion that I can make from viewing the surveillance videos is that Mr. Xxxxxxxx is performing reasonable activity. It is difficult to state the extent of pain that Mr. Xxxxxxxx suffered doing these activities. As suggested by Mr. Xxxxxxxx, Mr. Xxxxxxxx seems to have mild to moderate disability even during those periods that were included in the video surveillance.**
7. **Recovery following road traffic accident can vary considerably. Some individuals will settle within a matter of days to weeks and others may have symptoms for many months to years. Unfortunately there is no equation one can utilise to determine the period of recovery for each individual with every scenario. It is for this reason that 2 experts may describe an accident where the recovery varies considerably.**
8. **From the evidence available to me it is clear that Mr. Xxxxxxxx was working until the date of the index accident as a coach driver. He stopped work immediately following the index accident that occurred on 00/00/0000. Though he has had a history of some low back pain in the past there is no significant history of any neck pain.**
9. **When I examined him there was no obvious evidence of any exaggeration or malingering. I think he is genuine and that his complaints are real.**

10. **I accept the argument by the various experts that considering the mechanism of the accident the effects should have resolved within nine months following the index accident.**
11. **I however would like to quote the following two peer-reviewed medical articles. I have attached these articles along with this report.**
    a. **Whiplash injury. by Bannister G, Amirfeyz R, Kelley S, Gargan M. J Bone Joint Surg Br. 2009 Jul;91(7):845-50. Review.**
    b. **Whiplash injury: 30-year follow-up of a single series. Rooker J, Bannister M, Amirfeyz R, Squires B, Gargan M, Bannister G.J Bone Joint Surg Br. 2010 Jun;92(6):853-5.**
12. **The above articles clearly shows that 2 to 4% of patients have chronic severe disability which can be up to Grade D according to the classification by Bannister & Gargan. The description of Grade D is - severe, causing patients to lose their job and to rely continually on analgesia, orthoses and repeated medical consultations. The patients in the above two publications also sustained similar accidents as sustained by the Mr Xxxxxxxx.**
13. **My final opinion is that following a similar accident 96 to 98% recover to a great extent. Unfortunately 2 to 4% have severe chronic disability. On the balance of probabilities I believe that this was the case in Mr Xxxxxxx. He suffered severe chronic disability following the index accident.**
14. **My opinion is only on my areas of specialism - orthopaedics and musculoskeletal. I have no comments regarding the psychological effects following the index accident. These are being dealt with in separate reports.**

INTRODUCTION

I, Mr George Ampat am a Registered Medical Practitioner (General Medical Council Registration Number 4392747) and have been in clinical practice since October 1986. I have been a Consultant in Orthopaedics and Trauma with special interest in Spinal Disorders since January 2002 and I am a member of the Royal College of Surgeons, Glasgow. My academic qualifications include FRCS (Tr & Orth), MS (Orth), FRCS (Surg in Gen), Dip N B (Orth) & D.Orth.

I have produced reports for Road traffic accident victims and Personal injury cases for the last 14 years.

This report is completed following interview and examination of Mr. Xxxxxxxxon 00/00/0000 at Renacres Hall Hospital, Renacres Lane, Halsall, Nr. Ormskirk, Lancashire L39 8SE.

Documentation available to me at the time of the examination included a Letter of Instruction from M/s Xxxxxxxxxxx.

I had access to the contemporaneous medical records.

Claimants are provided with a questionnaire to fill in prior to the interview and examination. The questionnaire was received and filled in by Mr. Xxxxxxxx

The identity of the Claimant was checked by seeing his passport.

Mr. Xxxxxxxx attended along with is wife, Mrs. Xxxxxxxx, who was present during the entire interview and examination.

HISTORY

Mr. Xxxxxxxx tells me that he was involved in an accident on 00/00/0000. He says that he was waiting to turn right, when a lorry coming from behind collided to the rear of his car. He says that he was not knocked out and remembers all the details of the accident. He says that he was dazed for a few seconds, but, subsequently, managed to take his dogs from the car to his house which was nearby and then returned to the scene of the accident. He says the impact was significant and that it pushed his car forward by about 50 feet. He says that his seatbelt remained fastened and his car did not have any airbags. Subsequently, he exchanged details with the other driver. His car was not driveable. Police and ambulance attended the scene of the accident and ambulance took him to the XXXXXXXXX Hospital. He was interviewed and examined, and had x-rays. He was given diclofenac for the pain. He was discharged to home the same evening. He says that he has since met his GP on numerous occasions. He has had treatments with physio, osteopathy, pain clinic, psychiatry

etc. He has also been to Prime Care for pain therapy. He has attended the physiotherapy and osteopathy on at least two to three occasions.

TIME UNABLE TO WORK

Claimant has been off work completely from the time of the index accident till date.

TIME UNABLE TO DRIVE A MOTOR VEHICLE

He says that he has been able to drive but only for short periods.

TIME TAKEN TO RETURN TO NORMAL ACTIVITY

Claimant says that he has still not returned to normal activity.

PROGRESS ACCORDING TO THE CLAIMANT

Not enumerated.

CURRENT COMPLAINTS

1. Headaches. He says it started since the accident. On a scale of 0 to 10, it was 8/10 initially, currently it is 5/10. " Activity and stress seems to increase the pain and taking off the weight of the head and neck improves the headaches."
2. Neck and shoulder pain to both shoulders. He says it started since the accident. On a scale of 0 to 10, it was 8 to 9/10. He says currently it remains at 1 to 7. Stress, cold weather and over activity increase the pain. Lying down seems to help.
3. Pain in the lower back and mid back. He says it started immediately after the accident. On a scale of 0 to 10, it was 5-10/10 initially, currently it is between 3-8/10. Stress, cold weather and over activity increase the pain.
4. Legs and buttocks. He says it started immediately after the accident. On a scale of 0 to 10, it was 6 to 7/10 initially, currently it still remains at 6 to 7/10. He says that there are no particular aggravating factors and a hot bath seems to help. He says that he has had low and mid back pain in the past and that has been recorded in his medical records.

SPECIFIC DIFFICULTIES

AT HOME

Claimant says that he is unable to do any of the household chores. He says he can only make the bed about 50% of the time. The housing association has put in an extra stair rail to prevent him from falling down the stairs.

AT WORK

He has not been at work following the accident.

AT LEISURE ACTIVITIES

He says that he is unable to participate in any leisure pursuits like picnics etc.

PAST MEDICAL HISTORY

He has had a motorbike accident in 0000s when he broke his wrist and ankle.

DRUG HISTORY

Claimant is currently on tramadol four to eight tablets per day. He is on paracetamol four to eight tablets per day.

SOCIAL HISTORY

The claimant says he is currently unemployed. He used to work as a coach driver. He is married and has one daughter aged five. He has been on receipt of disability living allowance since September 2008. He is right-handed. He says he smokes about one ounce of tobacco every four days and that he drinks rarely**,** only on Christmas and on birthdays.

PERSONAL HISTORY

Claimant says his sleep is disturbed at least two to three times at night. He says, his height is 6 feet and his weight is 14 stone. He feels his weight has decreased in the last six months. The claimant says, he used to be about 20 stone when he was a teenager and then he has lost weight as he became older weighing around 18 stone. He has good control of his waterworks and bowels but suffers from constipation partly from the medication. He has some urge when passing water. He is able to climb a flight of stairs without being breathless.

VISUAL ANALOGUE SCALE

Visual analogue scale is a subjective method of assessing the level of pain. The Claimant is asked to indicate the level of pain by using the following guide. A 10-cm horizontal line as shown is drawn. The beginning of the line on the left has a value of 0 / 10 and indicates no pain. The end of the line on the right has a value of 10 / 10 and indicates the worst / most

severe pain that he could imagine. The Claimant is then asked to mark a point 'X' across this line to indicate the level of his pain.

0 1 2 3 4 5 6 7 8 9 10

Mr Xxxxxxxx scored the following values

1. Immediately after the accident 5 / 10
2. Twenty four hours after the accident 10 / 10
3. One week after the accident 9 / 10
4. One month after the accident 9 / 10
5. Three months after the accident 7 / 10
6. Now 4 / 10

PAIN DIAGRAM

The questionnaire provided to Claimants has a diagram of the front and back of the human body. Claimants are requested to mark on the diagram areas where they have pain.
He has marked the neck, the mid back, the low back, both the iliac crest, both the legs, both the arms numbness and tingling.

REVIEW OF MEDICAL RECORDS

All entries deleted to maintain Anonymity

EXAMINATION

GENERAL

Systemic enquiry revealed normal cardiovascular, respiratory, gastrointestinal, genitourinary and central nervous systems. He walked in with a stick but was able to walk within the clinic without the use of a stick. He had a long stick and used it in his right arm. Right appendix scar seen. Scar in the lower left lumbar region where he had a mole removed.

CERVICAL SPINE

On inspection there was a normal lordotic contour. Neck range of motion restricted by about 50% all directions. On palpation there was tenderness in the cervical spine and the paracervical muscles. No sensory, motor or deep tendon reflex deficit in both upper limbs. No long tract signs.

UPPER LIMBS

On inspection there was normal contour of both upper limbs. No evidence of any deformity, abnormal swelling or muscle wasting. Range of motion both the shoulders was restricted to 120° to 150°. He stated that any further abduction increased his low back pain. There was full range of motion in the elbows and wrists were normal. No tenderness on palpation in any part of the upper limbs. Distal pulsation in the radial well felt. Capillary refill in the nail beds was normal.

LUMBAR SPINE

On inspection there was normal lordosis. Expected range of motion in the lumbar spine. Straight leg raising was 70° bilaterally. Femoral stretch test was positive bilaterally causing back pain. Neurological examination showed sensory dulling in the left L5 and S1 dermatomes. There was no motor or deep tendon reflex deficit. On palpation there was tenderness over the bony spiny processes, the paraspinal muscles (both the lower thoracic and lumbar spine area) and both the sacroiliac joints. Faber's and pump handle was negative bilaterally.

LOWER LIMBS

On inspection there was normal contour of both lower limbs. No evidence of any deformity, abnormal swelling or muscle wasting. There was full range of motion in hips, knees and ankles. No tenderness on palpation of any part of the lower limbs. Distal pulsation in the posterior tibial and dorsalis pedis was normal. Distal circulation in the foot was normal.

DIAGNOSIS

1. Soft tissue injury to the neck causing ongoing pain in the neck and headaches with radiation to the shoulders. Still symptomatic even 5 1/2 years following the index accident.
2. Soft tissue injury to the mid and lower back causing mid and low back pain with radiation to the buttocks and legs. Still symptomatic even 5 1/2 years following the index accident.

CLINICAL IMPAIRMENT, DISABILITY AND PROGNOSIS

Definitions

Impairment = Loss, weakening, damage, or deterioration, especially as a result of injury or disease.

Disability = Inability to function normally, physically or mentally.

On the balance of probabilities there will be permanent clinical impairment and disability caused by the index accident.

DECLARATION AND SIGNATURE

I, Mr George Ampat declare that

1. I understand my overriding duty is to the court, both in preparing reports and giving oral evidence. I have complied with and will continue to comply with that duty.
2. 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.
3. 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 is required.
4. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters that 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.
5. I have drawn attention to all matters, of which I am aware, that might adversely affect my opinion.
6. Wherever I have no personal knowledge, I have indicated the source of factual information.
7. I have not included or excluded anything which has been suggested to me by anyone, including those instructing me, without forming my own independent view of the matter.
8. 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 and I may be cross-examined on my report by a cross examiner assisted by an expert.
10. I have not entered into any agreement where the amount of payment of my fee is in any way dependant on the outcome of the case.

Statement of truth:

I confirm 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 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.

Mr George Ampat MS FRCS (Tr and Orth)
Consultant, Trauma & Orthopaedics,