Medical Report

Prepared by

Ramzi Freij FCEM FRCS MBBS

Below is a résumé of my work experience:

Degrees held:
Bachelor of Medicine, Bachelor of Surgery, University of London 1986
Fellowship of the Royal College of Surgeons of Glasgow 1993
Fellow of the College of Emergency Medicine 1996

Previous and current NHS positions:
Consultant and Head of Service Mayday University Hospital 1996-2000.
Consultant and Head of Service East Kent Hospitals NHS Trust running five A&E Departments 2000-2004.
Consultant (Head of Service from 2005 to 2007) for Nottingham University Hospitals Emergency Services from 2004 to the present time.

Past and present positions held:
Medical Director of the Essex and Herts Air Ambulance Trust.
Medical Director of the Kent and Surrey Sussex Air Ambulance Trust.
Past Medical Director of the North West Air Ambulance Trust.
Member and Co-Founder of UK Helicopter Emergency Medical Services (HEMS)
Chairman of the Clinical Sub Group of the Air Ambulance Association and UK HEMS
Past Lecturer at University of Hertfordshire and Paramedical Sciences
Past Examiner for London Ambulance Service IHCD (Stage 1/Stage 2)
Past Examiner at the University of London

Publications:
Twenty Scientific Papers published.

Current Medical Practice:
I work in one of the busiest A&E Departments in Europe (160,000 attendees per annum). My everyday practice consists of seeing patients who are seriously ill or injured. I review patients who have an injury severity score of over 16. I have expertise in the management of major trauma and major illness. I also have expertise in the management of minor illness and minor injuries such as spinal soft tissue injuries and limb injuries. I manage upper and lower limb fractures. I also have expertise in the management of traumatic chest injuries. I am currently the ENP clinical lead and thus responsible for training and mentoring their practice through case based discussions and leading on development days.

Personal details

Name	
Date of Birth	
Address	
Occupation	Kitchen and bedroom fitter
Date of incident	22 January 2013
Date of examination	10 March 2014
Place of examination	Nottingham
Report Reference	RF/DR/
Prepared at the request of	
Reference	

Identification

1. I was able to identify Mr by his Passport.

History of incident

2. On 22 January 2013 Mr was at work in a client's house. He went to the garage to pick up a panel.

3. Mr walked over a mechanic's pit that had wooden slates covering it. Mr fell into the pit; he initially hit the left side of his chest on the side of the pit, he then dropped the panel and fell onto his right foot. He was able to lift himself out of the pit.

4. Mr then walked to the kitchen. After that, he walked out to cut the panel and then collapsed from the pain in his chest and leg. He phoned his daughter who took him to Bassetlaw Hospital.

5. Mr informed his manager who filled in an incident form.

6. Mr subsequently went to see his GP.

7. Mr has had physiotherapy.

8. Mr has had 6 months off work. He was certificated by his GP. He was on light duties for a further month.

Review of records

9. A summary from the Emergency Department of Bassetlaw Hospital confirmed that Mr attended on 22 January 2013.

10. He was at work in a garage; he stood on wood that gave way; he fell approximately 6 feet landing on his feet. He was complaining of pain to his right heel and pain to the left side of his chest which was worse on breathing. He underwent an x-ray, following which he was discharged.

11. Mr attended the emergency Department of Bassetlaw hospital on 26 February 2013 still complaining of pain in his right foot. He was given verbal advice and discharged.

12. Correspondence dated 16 May 2013, following a clinic on 14 May 2013, from the consultant orthopaedic surgeon indicates that Mr had injured his right foot during the course of his employment as a kitchen fitter; he had pain in his heel. He was walking with aids and he was complaining of pain around the calcaneum that was suggestive of plantar fasciitis. An x-ray of his foot revealed no bony injury and an MRI scan was organised.

13. An MRI scan report performed on 30 May 2013 and reported on 6 June 2013 indicates that there is no bony abnormality.

14. Correspondence dated 25 June 2013 indicates that Mr still had pain in his heel and there was no orthopaedic intervention required:

15. 20 January 2013: he had fallen in the pit in a garage and was complaining of pain to his heel and also chest pain that the GP felt might be as a result of fractured ribs. He was given a medical certificate from 22 January 2013 till 11 February 2013.

16. 8 February 2013: the rib pain was improving and his analgesia requirement was reducing. He was not fit for work for seven days.

17. 15 February 2013: he still had ongoing right foot and ankle pain. He was given a medical certificate until 4 March 2013.

18. 26 February 2013: he has ongoing problems and had been back to the emergency Department. He was given a medical certificate for three weeks.

19. 26 March 2013: still had ongoing pain and was given medical certificate for one month.

20. 17 April 2013: he was given a further medical certificate for one month.

21. 28 June 2013: he was discharged from orthopaedics and his MRI scan was normal.

22. 26 July 2013: he was given amitriptyline that did not help; he was also to try gabapentin. He informed his GP that when he applied ice to his ankle it gave a burning pain and did not feel cold.

23. The physiotherapy records indicate the possibility of nerve damage; he was reviewed twice.

Problems

24. Mr had chest pain for 5 weeks and he had completely recovered.

25. Mr has right foot pain; this is on his heel.

26. Mr has no pain in the morning.

27. Mr finds walking for 10 minutes causes pain.

28. Mr rates his pain as moderate.

29. Mr has cold intolerance.

30. Mr no longer plays badminton and he struggles to walk his dog.

31. Mr has occasional pain on standing for long.

32. Mr struggles to use his pushbike.

33. Mr uses Co-codamol, Paracetamol and Ibuprofen for analgesia.

34. Mr struggles to drive for long periods.

35. Mr had bruising for 12 weeks. He couldn't put "normal" shoes on for 12 weeks.

36. Mr was assisted by his wife in all activities of daily living for 3 months.

37. Mr used crutches for 5 months.

38. Mr hobbled for 7 months.

39. Mr had to sit when using a shower; he was assisted out of bed by his wife.

Examination

40. Examination of Mr 's chest revealed no abnormality.

41. Examination of Mr 's right foot revealed:

    - Gait normal
    - No swelling/bruising
    - Lateral scar from childhood operation
    - No loss of sensation
    - Tenderness over plantar fascia

Conclusion and Prognosis

42. Mr was involved in an accident.

43. He has a soft tissue injury to his right foot. The symptoms that he is complaining of are of plantar fasciitis but with significant pain.

44. He should undergo steroid injections. He should also be reviewed by a consultant in pain management due to the passage of time.

45. It is impossible to give a prognosis at this stage as he still has significant pain.

46. He had chest pain for 5 weeks which is reasonable.

Declaration and Signature

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.

Signature

Date