Orthopaedic & Trauma Services Limited
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FIRST MEDICAL REPORT FOR THE COURT

NAME:	[redacted]
ADDRESS:	[redacted]
DATE OF BIRTH:	[redacted]
OCCUPATION:	Was forklift truck driver/Picker Currently on DLA Right hand dominant
DATE OF ACCIDENT:	[redacted]
DATE OF EXAMINATION:	14 February 2017
DATE OF REPORT:	2 March 2017
OUR REFERENCE:	[redacted]
SOLICITOR'S REFERENCE:	[redacted]
INSTRUCTIONS FROM:	[redacted]
REPORT PREPARED BY:	Professor Sanjiv Jari

This is a condition and prognosis report on [redacted] after interview and examination for the purpose of the report on 14 February 2017. The report was prepared following instruction from [redacted]

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SUMMARY AND CONCLUSIONS

On [redacted], [redacted] was at work when he sustained a minor soft tissue inversion injury to his left ankle.

He was investigated extensively by the Orthopaedic Surgeons and absolutely no structural abnormality was found to explain his symptoms. He has subsequently been diagnosed with a CRPS.

His ongoing complaints are outside the field of Orthopaedic surgery and are best prognosticated by Pain Physicians and Psychiatrist's. There are a number of contradictions in his history between what he has informed various professionals. These contradictions and inconsistencies potentially suggest a significant degree of non-organic overlay to his ongoing symptoms.

He has a significant past history of recurrent back pain and significant periods of time off work due to his back pain and sciatica. Individuals who suffer with back pain tend to get recurrent episodes during their lifetime and this is likely to have therefore occurred as he aged. It is also likely to have got somewhat worse as he aged. It is likely he would have reached a point where his back would have limited him from heavy manual work as this is one of the restrictions placed on individuals who are getting recurrent significant back pain.

He has suffered with previous arthritis in his right ankle following an ankle fracture. He underwent an ankle fusion. It is likely that irrespective of his index accident his right ankle would have restricted his ability to have undertaken heavy manual work and occupations involving prolonged periods of standing and or walking.

DOCUMENTS AVAILABLE

Letter of Instruction from [redacted] dated 21 November 2016

Particulars of Claim

Schedule of Special Damages

Reports of [redacted], Consultant Orthopaedic Surgeon

Report of [redacted], Consultant Psychiatrist

Report of [redacted], Pain Physician

Copy of Hospital Records.

Copy of GP Records.

Copy of Updated GP Records

DWP Records

Further DWP records received for review on 27 January 2017

CCTV footage

Completed Medical Report Questionnaire.

INSTRUCTIONS

The letter of instruction instructs me to interview and examine [redacted] and prepare a medical report. I have been instructed to review the medical records. The instruction letter notes from the claimants solicitor *"my client has asked me to inform you that the examining expert should not touch* [redacted] *foot and he finds this very painful and troubles him greatly. Please direct the Doctor to be very careful and not to touch the foot at all. Pain is not improving and in my clients view is getting worse (recently)."*

METHODOLOGY

This report is intended to be entirely independent and is prepared on the basis of instructions received from [redacted] during his interview, observations and physical examinations performed by myself in my consulting room on 14 February 2017. [redacted] was accompanied by his wife for the purpose of the interview and examination. There were no communication difficulties. There were no tests or experiments conducted.

I have noted the solicitor's instructions above but also note that the claimant's experts were able to examine his foot. I too was able to undertake some degree of an examination of his foot.

SUMMARY CV

I, Professor Sanjiv Jari, am a Consultant Trauma and Orthopaedic Surgeon at Hope Hospital in Salford and was appointed in 2001. I am also an Honorary Senior Lecturer in Orthopaedic & Trauma Surgery at the University of Manchester. My clinical practice routinely involves management of upper and lower limb trauma. I have a special interest in lower limb and knee trauma with my elective interests being lower limb surgery, including ligament reconstruction, joint replacements and sports medicine.

I am the Founder and Co-director of the Manchester Sports Medicine Clinic, which has been running successfully for over 8 years dealing with Orthopaedic conditions and Sports injuries in elite athletes and the general public.

I am a fellow of the Royal College of Surgeons of England, and have been since 1994. I have been fully registered with the General Medical Council since 1991 and I am on the Specialist Register for Trauma and Orthopaedic Surgery.

My qualifications include B.Sc (Honours), M.Sc.Ch.B, FRCS (Eng), FRCS (Tr & Orth) and I have a Sports Medicine Fellowship Diploma from the University of Indiana, in the USA.

In May 2013, I was appointed as Professor within the Faculty of Engineering, Science and Sports at the University of Bolton.

I am a member of the UK register of Expert Witnesses and The Association of Personal Injury Lawyers and a member of the Manchester & District Medico-Legal Society. I have attended

some medico-legal courses on report writing and court attendance. I have successfully attained the Medico-legal Expert Witness Certificate in conjunction with the BOA, City University and Inns of Court School of Law (2007). I have been invited as a Faculty member at medico-legal conferences and have lectured on various personal injury topics.

I have published a BSc Thesis, 17 peer-reviewed articles in a number of respected international journals and a number of invited articles including book chapters. I have 28 podium presentations at various Orthopaedic meetings around the world and continue with on-going research studies in specific aspects of Orthopaedics and Trauma.

My professional memberships include the British Orthopaedic Association, American Academy of Orthopaedic Surgeons, British Trauma Society, British Orthopaedic Sports Trauma Association and The British Association of Sports and Exercise Medicine.

I undertake between 400-600 reports per year. I have been preparing medical reports since 1996. My instructions are split about 50% claimant, 20% defendant and 30% joint instructions. I am also being instructed on an increasing number of medical reports for the Court in claims of alleged medical negligence.

1. HISTORY FROM CLIENT

1.1. [redacted] is a 53 year old right handed gentleman who informs me he was at work on [redacted] He was wearing work boots. He states he was walking through the warehouse when his left foot went in to a pothole. He "inverted" his left ankle and fell to the ground. He later mentioned that he had done a jump before the accident occurred. He states, however, he cannot remember why he did the jump.

1.2. He states he got up with help and he stopped working and immediately went to the hospital.

1.3. He had immediate swelling in his left ankle. He also had tingling in his ankle.

1.4. He went to Chesterfield Hospital where he had x-rays of the ankle and was told he had torn ligaments. He was given painkillers and advised to elevate. He subsequently was put into a cast for 8 weeks and then had physiotherapy. The physiotherapy did not help him.

1.5. He was referred to the pain clinic, which is ongoing.

1.6. He is not under Orthopaedic follow-up.

2. CURRENT SITUATION FROM CLIENT

2.1. [redacted] rates himself as having a significant handicap. He states his left foot and ankle have got worse since the accident.

2.2. He states that he has a burning, tingling, buzzing pain and sweating of his left foot on the dorsolateral aspect of his foot and the dorsum of his foot and also, for the last 3 or 4 months, it has been spreading to the pad on the under surface of his foot. He states these symptoms started once his cast was removed. He states his foot is freezing cold and swells. It goes blue spontaneously. It is hypersensitive and he cannot touch it. He wears a flip flop on his foot if he goes out but is not able to tolerate anything else.

2.3. He walks with 2 crutches both inside and outside his house. He states he is not able to put his foot on the floor.

2.4. He takes Tegretol for his pain as well as Oxycodone. He is on Capsaicin cream. He is also on Duloxetine as an antidepressant.

3. OCCUPATION FROM CLIENT

3.1. [redacted] was a forklift driver and picker working 60 hours a week at the time of his accident.

3.2. Following his accident he has never returned to work. He is not sure when he lost his job as he states his employers never told him. He was initially on statutory sick pay for 26 weeks and then went on to employment support. For the last 3½ years he has been on high level DLA.

4. SOCIAL HISTORY FROM CLIENT

4.1. [redacted] is married. He has 3 children aging in range from 24 to 30 years of age. He lives with his wife in a house.

4.2. He has had a stair lift fitted because he cannot walk up and down the stairs.

4.3. He states that since the accident requires assistance with having a bath and cannot dress his lower body and this has to be done by his wife.

4.4. He does not drive a car.

4.5. He has not been able to undertake any domestic activities apart from occasional washing up if he is sitting down. He states he can do some vacuuming if he is on his hands and knees.

4.6. He has been given a wheelchair but does not use this.

5. RECREATIONAL ACTIVITIES FROM CLIENT

5.1. Prior to the accident he used to do DIY weekly, gardening 2-3 times a week, golf weekly and walking his dog daily. He has not been able to return to any of these activities.

6. PAST MEDICAL HISTORY FROM CLIENT

6.1. He states he had a significant injury to his right ankle in his 20's when he jumped off a wall that was 4ft high on one side and 45ft on the other side. He eventually underwent an ankle fusion 2 years ago.

6.2. He has had no previous problems with his left ankle.

6.3. He stated he had had no other accidents or claims (his medical records however indicated that he has had other accidents).

6.4. He is diabetic. He has a history of depression and anxiety for 6 months prior to his index accident he stated.

7. PSYCHOLOGICAL STATUS FROM CLIENT

7.1. He suffers with anxiety and insomnia.

8. EXAMINATION

8.1. [redacted] was a well looking gentleman who walked with 2 crutches, non-weightbearing on his left foot. He informed me he was 6 feet and 1 inch tall and weighed 16 stones and 7 pounds.

8.2. When he arrived in the building there are a series of about 8 stairs, which he negotiated with difficulty using his crutches and weightbearing on his other leg, even though his wife stated he had to come up the stairs on his bottom. This is not correct as by coincidence, I actually saw him coming up the last 3 or 4 steps on his crutches and weightbearing on his other leg.

8.3. He was wearing flip flop type sandal with a wide strap on the dorsal aspect of the flip flop which went across the dorsum of the foot and measured about 5 or 6cm in width. He removed this flip flop in the waiting room and arrived in the consultation room without it but did it have it with him to show me that it was the only footwear he was able to wear.

8.4. He stated he was not able to put his left foot on to the ground. He was, however, able to put his left foot to the ground to help him get off the chair. He was also able to stand for a short period of time while getting dressed without his crutches and his left foot lightly weightbearing on the floor.

8.5. He required the help of his wife getting his trousers on and off and as the trousers went across his left foot he was complained of marked pain.

8.6. His left foot and ankle were discoloured and were a reddish colouration. His nails were not dystrophic. He stated that he did not want me to touch his left foot except on his left heel, which was non-tender. He had thickening of the skin on his heel on the left and right foot, suggesting he is able to weightbear on his heel. He allowed me to touch the anterior aspect of his left ankle, which was painful and was perhaps a little reduced in temperature compared to the right side (but on the right side he had been wearing a shoe and a sock which would keep that foot warmer).

8.7. He had some puffiness of his ankle and foot compared to the right side.

8.8. He had no active range of motion of his ankle or toes and I could not assess passive range of motion.

8.9. His left calf had some minor wasting compared to his right side, but was not to a degree that I would have expected in someone who had apparently not been weightbearing for 4 years.

8.10. He had a symmetrical range of knee motion bilaterally.

9. REVIEW OF RECORDS

9.1. Particulars of Claim

9.1.1. It is noted that at *"Approximately 13:30, while so walking, the claimant was called by a colleague and he turned and spoke to him briefly over a distance. He turned away with something of a flourish, perhaps a skip and jump, and as he landed his left foot entered a pothole and he suffered and injury to his ankle"*.

9.1.2. The particulars of injury note that following his injury to his left ankle he had gone on to develop chronic regional pain syndrome and suffered psychological injury and handicap in the open labour market.

9.2. Schedule of Special Damages dated [redacted]

9.2.1. I have read through this document and noted its contents.

9.3. Medical report by [redacted], Consultant Orthopaedic Surgeon, dated [redacted]

9.3.1. The history section notes *"*[redacted] *was walking in a warehouse at work. When he put his foot into a pothole he believes he inverted is left ankle"*. It was noted a couple of days later his ankle gave way again and he returned to the A&E department. It was noted he was seen by a Foot and Ankle Surgeon who found no objective abnormalities. [redacted] underwent an examination under anaesthetic, which revealed no abnormality. He had an MRI scan, bone scan and ultrasound scan, all of which revealed no structural defect within the ankle.

9.3.2. A diagnosis of a regional pain syndrome was made and he was referred to the pain physician. The report notes that at the time of his assessment he had chronic pain present 24 hours a day. He could not put his foot to the floor without pain. He mobilised with crutches. His foot would change colour regularly. He had a buzzing sensation, burning sensation and tingling in the foot. He had numbness in his little and ring finger of his left hand, which he had apparently been told were secondary to using crutches and ulna nerve irritation. He was also *"extremely depressed"*.

9.3.3. In the past history it was noted he had no previous problems with his left ankle. It had a significant injury to his right ankle a number of years ago which was treated surgically. It was noted he had no long term problems following his ankle injury but recently his right ankle had become increasingly painful *"probably secondary to taking the increased load"*.

9.3.4. He had not worked for 14 months. He had not been able to undertake any recreational or social activities.

9.3.5. When he was examined, he was walking with 2 crutches and his left foot had minimal contact with the floor. It was noted that when he undressed his left foot was clearly a different skin nature to the right foot with the skin being thinned and hairless. It was mottled red and blue and had marked hypersensitivity to contact on the lateral side of the foot, the dorsum of the ankle and lateral side of the ankle. With careful examination it was noted he had just beyond 90° of dorsiflexion and almost full plantar flexion within the limits of his pain.

9.3.6. In the prognosis it was noted he sustained a soft tissue injury to his left ankle 14 months previously. He had an uncomplicated ankle sprain. It was noted he would have been expected to have been off work for 1 month and then light duties for 1 month with restriction on sport for a further 1-2 months. He was expected to have made a full and pain free recovery with no long term sequelae. His recovery unfortunately was complicated by chronic regional pain syndrome, which was noted to be *"a fairly unusual and very debilitating condition"*. A report from a Pain Physician was recommended. No long term Orthopaedic problems were felt should occur as a result of his index injury.

9.3.7. It was noted that following a significant ankle sprain, a small proportion of patients would develop a residual instability, but the vast majority would recover well in the normal course of events.

9.4. Second medical report by [redacted] dated [redacted]

9.4.1. In the history it was noted there had been no change in the symptoms in his foot. Since he was last seen he had a fusion of his right ankle.

9.4.2. It was noted he was not able to wear shoes and socks because of the pain in his foot and wore a flip flop to walk.

9.4.3. There was no significant change in the opinion or prognosis with regard to his left ankle.

9.5. Medical report by [redacted], Consultant Psychiatrist, dated [redacted]

9.5.1. I have read through the report and noted its contents.

9.5.2. It was noted that under the history of the accident *"On the day of the accident* [redacted] *was at work. He was walking down the middle of the main warehouse. He engaged in some banter with some fellow workers who were to the right of him, before he carried on walking. Without realising he put his foot in a pothole"*.

9.5.3. It was felt that he had developed *"significant psychological symptoms following a work related accident in July 2012"*.

9.5.4. It was felt that his potential to make a full and complete recovery from his depressive episode would hinge on his chronic regional pain syndrome.

9.6. Medical report by [redacted], Consultant Pain Physician, dated [redacted]

9.6.1. I have read through the report and noted its contents. The examination note states he entered the examination room using 2 crutches putting minimal weight on his *"right foot"*. I assume this should be his left foot. It was noted his left foot was blue compared to the right, with a blue red discolouration. There was wasting of the left calf muscles. His left foot was cooler than his right. He had *"extreme tenderness"* to touch over the top of the foot and underneath to the degree that he would not allow the physician to touch his foot. He was noted to have reduced hair growth on the left foot compared to the right, with no obvious differences in nail growth. There was no difference in sweating.

9.6.2. In the opinion there is a section relating to CRPS, but in [redacted] opinion, it was felt the physical symptoms on their own did not fully explain the claimants pursued level of

instability. It was felt important to consider non-physical factors in his presentation. He considered, but ruled out, the claimant was exaggerating his symptoms and in his opinion he felt he was genuine in his perceived levels of pain, disability and distress.

9.6.3. It was noted he had developed significant psychological and psychiatric problems which had amplified his perceived levels of pain and disability.

9.6.4. It was noted he had a significant history of depression prior to his accident.

9.6.5. Treatment for *"intensive therapeutic input from a team experienced in managing CRPS"* was recommended.

9.6.6. With regard to a prognosis, it was recommended he was reassessed in 12 months. It was felt he was not able to work due to his physical, psychological and psychiatric condition.

9.7. Hospital Records from Chesterfield Hospital

9.7.1. 19 July 2012, A&E attendance noting that he had an injury to his left ankle. The clinical entry noted that he had gone over on his left ankle. There was swelling and limited movement. There was no bruising. Sensation was felt. He refused painkillers. An x-ray was requested. It was noted that he had inverted his left ankle in a pothole at work and had swelling and pain. He was able to weightbear.

9.7.2. When he was examined, there was some swelling and tenderness around the lateral aspect of the ankle. He was sent for an x-ray which revealed no bony injury. He was advised painkillers, rest, elevation and gentle mobilisation.

9.7.3. 19 July 2012, x-ray report left ankle *"There is soft tissue swelling over the lateral malleolus. No fracture seen. The ankle mortise is aligned well"*.

9.7.4. 27 July 2012, A&E attendance noting he had an injury to his left ankle. It was noted he had fallen in a pothole on 19 July 2012 and was advised to return if he had any problems. He had been having pain since and was unable to weightbear. The day he attended, he had gone over again on the same ankle.

9.7.5. 3 August 2012, handwritten entry noting he had attended the A&E clinic. He had 2 inversion injuries of the left ankle and was tender over the lateral ligament complex. He was unable to weightbear. A below knee back slab was applied and he was advised to remain non-weightbearing.

9.7.6. 3 August 2012, letter from A&E consultant noting that on 27 July 2012 he attended the department having had an inversion injury to his left ankle on 2 occasions. X-rays revealed no bony injury but showed extensive soft tissue swelling over the lateral ligament complex. He was unable to weightbear. His ankle movements were restricted by pain and he was very tender over the lateral ligament complex. He was treated in a below knee cast and given painkillers. When he was reviewed in clinic, he was advised to continue the cast for a further 2 weeks and was given further painkillers.

9.7.7. 17 August 2012, letter from the A&E Department when he was seen with a diagnosis of grade II sprain left ankle. He was 3 weeks following his injury. He was still having a lot of pain with the ankle and was unable to weightbear. The swelling and bruising had

resolved. He was tender around the lateral ligament complex and lateral malleolus with movements being very restricted. It was explained he had a grade II sprain and his symptoms could take 6 weeks to get better. As he was still very symptomatic, he was immobilised in a below knee cast for a further 2 weeks and given painkillers.

9.7.8. 31 August 2012, letter from A&E consultant when he was seen 4 weeks following his ankle injury. He had been in a below knee cast followed by a full equinus cast for another 3 weeks and was still in considerable pain. His ankle was stiff and tender all over. He was put in a walking boot and referred to physiotherapy.

9.7.9. 1 September 2012, ambulance service record noting he was a front seat passenger in a middle car which was in a 3 vehicle shunt. It was noted his left leg was strapped up following ligament damage and nerve damage. His left leg did impact the passenger footwell but there were no signs of new injury.

9.7.10. 1 September 2012, A&E attendance noting he had a road traffic accident that evening. He was stationary in traffic when a car went into the back of his car pushing his car into the car in front. He was complaining of neck pain.

9.7.11. I have had sight of physiotherapy records. It would appear he was assessed on 31 August 2012. 6 weeks previously he stood in a pothole and went over on his left ankle. He could not weightbear through the ankle or moves the ankle.

9.7.12. 4 October 2012, physiotherapy letter noting that he had been seen with a grade II sprain of his left ankle on 31 August 2012. Initially he was in a lot of pain and struggled to move his ankle. He was tender on palpation to the lateral malleolar. His movements had

improved but he was unable to weightbear 8 weeks post-injury. Forced dorsiflexion squeeze test, heel thump test, forced external rotation and cross legged tests were all positive indicating syndesmosis injury of the left ankle. It was felt he required prompt referral to orthopaedics.

9.7.13. 5 October 2012, letter from the Emergency Department to the Orthopaedic Consultant noting he was to be reviewed in the upcoming fracture clinic. He was 11 weeks following his injury when he fell down a pothole at work. He had been very significantly disabled by his injury. He had 6 weeks in a cast and then in a walking boot. He had been referred back by the physiotherapist who was concerned about a syndesmosis injury of the left ankle. He had significant ongoing pain and was unable to weightbear despite wearing the walking boot daily. It was thought he had been compliant with his physiotherapy exercises. He was very frustrated not to be at work and his pain and mood were suffering. It was queried if an MRI scan was of value.

9.7.14. 10 October 2012, letter from Orthopaedic Consultant when he was seen 12 weeks after he inverted his ankle. He had been treated for an ankle sprain. His symptoms were not settling. X-rays showed no bony injury. When he was examined he had anterolateral swelling of the distal tibiofibular syndesmosis and it was agreed with the physiotherapist that his examination was classical for a syndesmosis injury rather than a lateral ligament injury. It was felt this would settle. An MRI scan was arranged. It was noted there was a possibility he would need surgical reconstruction. He would be reviewed with an MRI scan with a view to being put on the trauma list.

9.7.15. 16 October 2012, MRI scan report left ankle *"No bone or joint oedema is seen. There is no bony oedema. The ligaments and tendons appear normal on this scan. No evidence of an avulsion injury or tendinopathy"*.

9.7.16. 17 October 2012, letter from Orthopaedic Registrar when he was seen with a diagnosis of left ankle sprain. He had had his MRI scan but it had not been reported. The scans were reviewed and there was no fracture, osteochondral defect or obvious soft tissue swelling. When he was examined there was no sign of instability of the ankle. He had a very good range of motion but was very tender over the lateral ligament. He was advised to continue with his boot and was to be reviewed in a weeks' time when the MRI report would be available. The doctor had a suspicion that he may have a reflex sympathetic dystrophy and if the MRI report did not find a source for his complaint then it was felt he should be referred.

9.7.17. 24 October 2012, handwritten entry from Orthopaedic Registrar noting he had a left ankle sprain with queried instability. The case was discussed with the consultant and it was felt he should have an examination under anaesthetic and if it was positive he may need a stabilisation.

9.7.18. 24 October 2012, letter from Orthopaedic Registrar noting that the official report of the MRI scan was negative. The case was discussed with the consultant and he was offered an examination under anaesthetic on the trauma list. If there was any laxity or torn ligaments, despite the negative scan, he was offered a stabilisation or reconstruction following which he would be in a cast for 6 weeks non weightbearing.

9.7.19. 1 November 2012, handwritten operation note when he underwent a diagnostic injection of local anaesthetic into the left ankle syndesmosis and examination under anaesthetic of the left ankle under image intensifier. The findings revealed a stable left ankle. The examination under anaesthetic showed no sign of instability. Under image guidance local anaesthetic was injected into the syndesmosis.

9.7.20. 14 November 2012, letter from Orthopaedic Registrar. He had undergone the examination under anaesthetic and manipulation of the left ankle. No abnormality was found and no lax ligaments. The MRI scan had not been reported to show any injury to the articular surface or osteochondral defect. The syndesmosis was injected with local anaesthetic but this did not provide any relief. He had complaints related to pain at the level of the ankle when he weightbears. When he was examined there was no swelling or redness and no obvious signs of reflex sympathetic dystrophy. It was advised he continue physiotherapy and was to be reviewed in 3 months. He was referred to the pain management team.

9.7.21. 14 November 2012, letter to the pain management team reiterating his history. It was noted he had an MRI scan which was normal and had an injection of the syndesmosis, which did not relieve his pain. His examination revealed no signs of sympathetic dystrophy, but excruciating pain when he weightbeared fully on his left lower limb. He was complaining of some tingling and numbness in his left foot.

9.7.22. 12 September 2012, letter from Dr Farquhason, consultant in anaesthesia and pain management. The letter noted that he had an incident at work when he injured his left ankle and continued to complain of severe pain around the left lateral malleolus on weightbearing. The letter notes *"interestingly when he has the external support boot on he*

can weightbear without any problem and has little pain although he is aware of an unpleasant parasthesia around the left lateral malleolus even with the boot on his foot". It was noted there was no mechanical explanation for his symptoms. He had previous problems with his right ankle and had surgery in the past. The claimant noted that he experienced pain in his left ankle on weightbearing which felt very similar to those in his right ankle, but more severe. It was noted that he had apparently badly injured his lumbar spine several years ago jumping off a very high wall and sustained crush injuries to his lower lumbar discs. He had no residual lumbar symptoms and his symptoms were not suggestive of a radiculopathy. When he was examined it was noted that the doctor was unable to discern very much other than extreme tenderness to palpation around the lateral malleolus. He described some subjective alteration and sensory acuity over that side of the foot. There were no obvious trophic changes to suggest CRPS or any change in any hair or nail growth. His wife stated however that the foot changed colour and became quite mottled on occasion. It was noted there were no hard signs of CRPS and *"perhaps some soft symptoms and given his level of distress and lack of alternative explanation I think we should perhaps consider if there might be an element"*. It was arranged for him to have a left sided steroid regional block. It was queried if there were any underlying metabolic problems which could prone him to neurogenic symptoms and he was sent for tests. It was felt worth considering that if his symptoms did not settle whether nerve conduction studies should be undertaken. Medication was suggested. It was felt he would require input from a clinical psychologist.

9.7.23. 2 January 2013, discharge summary noting he was admitted and discharged on 2 January 2013 and underwent a steroid regional block in his left leg.

9.7.24. 29 January 2013, letter from pain physician to the clinical psychologist noting that he had injured his left ankle in July 2012. He had been investigated by the Orthopaedics and there was no abnormality. He had an examination under anaesthetic with no abnormality. He had an injection of his ankle which did not help. It was noted that he had injured his foot which had occurred because he stepped into a pothole and then it was noted he had a subsequent road traffic accident. He had been unable to work since the accident. He had an old injury to his right foot which caused him pain at times. He had a nerve block and was on medication with a view to further injections.

9.7.25. 20 February 2013, bone scan report *"increased dynamic and static update is seen in the right. Static uptake suggests the presence of right ankle joint degeneration. No left side abnormal uptake is seen to account for left sided symptoms"*.

9.7.26. 26 February 2013, letter from Orthopaedic Registrar when he was reviewed. It notes that he had a sprain which was very innocuous back in July 2012. Since then he had persistent pain which sounded like CRPS. His MRI scan showed no abnormalities. He had an examination under anaesthetic which revealed a stable ankle. When he was examined the doctor could not elicit any pain whatsoever. He had full range of movement in the ankle. He had some movement of the subtalar joint which was painful. It was painful when he was weightbearing. It was felt he had a CRPS with features of swelling discomfort discolouration and stiffness due to pain on weightbearing. There was an element of a possible mechanical problem. He was to have a bone scan. It was noted the bone scan was normal and there was nothing further that could be offered from an Orthopaedic perspective.

9.7.27. 12 March 2013, letter from Clinical Psychologist noting that he had had a difficult year. He had a difficult year. He had a primary pain problem in the left ankle. He had fresh problems with his right ankle. He had high blood pressure and had been diagnosed with Type II diabetes. He had a road traffic accident and had financial problems. He had been absent from work for several months.

9.7.28. 13 March 2013, letter from Orthopaedic Registrar noting that his bone scan was normal with some slight increased uptake in the right side, which was his unaffected side, although he had an injury in the past, suggesting some degenerative changes. It was emphasised there was no structural cause for his pain and there was nothing further the orthopaedics could offer him. He was discharged.

9.7.29. 24 April 2013, letter from a physiotherapist noting that he had first presented on 31 August 2012 following an ankle sprain. His history was reiterated with regard to his investigations and treatment under the pain physicians. He had graded motor imagery approach, which due to various reasons was ineffective. He had been discharged by the Orthopaedic team and was under pain management. It was discussed by the physiotherapist with [redacted] that he should focus on his management under the pain clinic and clinical psychological and hold off from physiotherapy. He was discharged from physiotherapy.

9.7.30. 1 August 2013, letter from pain consultant. It was noted *"I do think there is an element of CRPS here. I am struck however with the fact that this gentleman is walking quite well*

when he was using an airboot but as soon as it came off he apparently cannot weightbear". It was felt that despite normal imaging this sounded more mechanical.

9.7.31. 1 August 2013, letter from Pain Consultant to Orthopaedic Consultant reiterating the history. It was noted he had been reviewed by a succession of the Orthopaedic Registrars but giving the ongoing symptoms it would be valuable for the Consultant to review him. From a pain perspective, there were considering doing a dorsal column stimulator.

9.7.32. 4 October 2013, letter from Orthopaedic Consultant to the Pain Physician noting that they had exhausted the remit of orthopaedic investigation the last time and there was no cause. He was still extremely painful to light touch and described classical chronic regional pain syndrome. His ligamentous complex was symmetrical and stable. It was felt there was nothing further that could be offered to him.

9.7.33. 12 February 2014, letter from pain consultant noting that he may need a fusion of his right ankle and had ongoing CRPS symptoms in his left ankle. It was queried that as he had a history of depression he may benefit from assessment by a psychiatrist. He was referred to Sheffield for a dorsal column stimulator. He was tending to overuse his painkillers.

9.7.34. 8 July 2014, letter from Orthopaedic consultant when he was reviewed noting that he had CRPS in his left ankle. He had a bone scan which showed increase uptake in the right ankle following a significant fracture many years ago, suggesting degenerative changes. He was on very strong painkillers for his CRPS which did not help him. He was walking with 2 crutches. He was not overweight. There was little else that could be offered from a

non-surgical perspective. The only option was a fusion, which was to be done arthroscopically and the risks were discussed. He was listed for this.

9.7.35. 9 July 2014, letter from senior occupational therapist in the pain service in Sheffield noting that initially [redacted] has been quite positive about the plan but when he was reviewed he felt unable to engage in the work that had been planned due to the intensity of his pain that he was living with. It was felt therefore there was little point him attending the pain clinic in Sheffield and he was discharged.

9.7.36. 30 September 2014, letter from Orthopaedic Consultant when he was seen prior to his right ankle fusion and was keen to proceed.

9.7.37. 29 October 2014, typed operation note when he underwent a right ankle arthroscopic fusion. The ankle was debrided. Wires were advanced into the joint under direct visualisation. The foot was placed planter grade in a neutral flexion. The wires were drilled and 2 screws inserted over those. X-rays were taken. Postoperatively he was to be non-weightbearing for 6-8 weeks. He was to wear a boot for 6 weeks. He was to have antibiotics and DVT prophylaxis.

9.7.38. 19 November 2014, letter from Orthopaedic registrar when he was reviewed. He was in a below knee cast for 3 weeks non-weightbearing. He was to stay in that for a further 3 weeks and would be reviewed at that stage.

9.7.39. 10 December 2014, letter from Orthopaedic consultant when he was seen 6 weeks following his ankle fusion. Clinically and radiologically there were no problems. He was to start weightbearing

9.7.40. 3 February 2015, letter from Orthopaedic consultant when he was seen 12 weeks following the ankle fusion. This had healed clinically and radiologically. He had CRPS in his other leg but did not have any evidence of this on the operated side. He was referred for physiotherapy.

9.7.41. 5 May 2015, letter from Orthopaedic registrar when he was seen 6 months following his ankle fusion. He was delighted with his fusion and was doing very well. He had no pain. X-rays demonstrated a union. He was discharged.

9.8. Review of Radiology from Chesterfield Hospital

9.8.1. 19 July 2012 x-rays of the left ankle. There is no bony injury evident. Joint spaces are well preserved. There is minimal soft tissue swelling laterally.

9.8.2. 27 July 2012, x-rays of the left ankle. There is no bony injury evident. The joints spaces are well preserved. There is somewhat likely greater swelling of the lateral soft tissues than compared to the previous x-ray.

9.8.3. 16 October 2012, MRI scan of the left ankle. I would be reliant on the radiologist's report in the assessment of this imaging. To my view there does not appear to be any bony injury evident.

9.8.4. 20 February 2013, bone scan imaging. My interpretation is that there is increased uptake around the right ankle and foot. The left ankle and foot appears normal.

9.8.5. 8 July 2014, x-rays of the right ankle. There is no bony injury evident. There is some irregularity of the joint space laterally.

9.8.6. 29 October 2014, intraoperative x-rays show what appears to be an ankle fusion of the right ankle.

9.8.7. 10 December 2014, x-rays of the right ankle showing 2 screws running from the tibia into the talus for an ankle fusion. Some of the joint space is still visible.

9.8.8. 3 February 2015, x-rays of the right ankle showing what appears to be a fused right ankle with metal screws insitu.

9.9. GP Records

9.9.1. The GP computerised consultation entries run up to 6 October 2015.

9.9.2. January 1982, GP entry noting he had an L1 and L4 fracture of the lumbar spine.

9.9.3. January 1982, GP entry noting he had a closed fracture of the distal right tibia.

9.9.4. 2 September 1991, GP entry noting he had back pain for 6 years.

9.9.5. 12 September 1991, GP entry noting he was given a sick note for back pain for 2 weeks.

9.9.6. 12 September 1991, GP entry noting that he was *"always nervy-social phobia".*

9.9.7. 24 January 1992, GP entry noting he had a wedge fracture of L4.

9.9.8. 1 September 1992, sick note issued for 3 months for back pain.

9.9.9. 7 December 1992, sick note issued for 3 months for back pain.

9.9.10. 9 December 1992, GP entry noting he was having back trouble and his ankle was also giving way at times.

9.9.11. 21 January 1993, GP entry noting a sick note was given for 3 to 6 months for his back and his ankle.

9.9.12. 24 August 1993, letter from Orthopaedic Registrar when he was seen noting that he was having problems with his right ankle following an intraarticular fracture in 1982. He had severe pain in the medial side which gave him the feeling that his ankle was giving way. He was adamant he wanted his screws to be removed and he was added to the waiting list for this.

9.9.13. 21 September 1994, GP entry noting he was given a sick note for his back and his ankle.

9.9.14. November 1994, GP entry noting he had removal of metalwork from his right ankle.

9.9.15. 7 May 1995, GP entry noting he was given a sick note for 6 months for his back and his ankle.

9.9.16. 4 July 1995, letter from Orthopaedic Consultant noting he was having ongoing problems with catching, the pain on the medial side stopped him walking. His x-rays suggested some degenerative changes medially between the talus and anterior tibia. It was felt that

the only way to progress would be to do an ankle fusion, which they did not prefer to do. He was to be reviewed in 6 months.

9.9.17. 2 January 1996, letter from Orthopaedic Staff Grade when he was seen 4 years following his right ankle injury. He continued to have problems with his ankle giving way. The ankle was not painful. Further x-rays showed similar appearances to before. It was discussed with the consultant and it was felt it may be worth doing an arthroscopy of his ankle for which he was listed.

9.9.18. 22 February 2005, GP entry noting he had back pain down his right leg to his knee.

9.9.19. 7 March 2005, GP entry noting a sick note was issued for a slipped disc and sciatica.

9.9.20. 18 November 2007, GP entry noting he had panic attacks.

9.9.21. 25 August 2011, GP entry noting he had been low in mood for several years.

9.9.22. 1 September 2011, GP entry noting he had stress at work and at home and had a bereavement.

9.9.23. There are further entries until 24 September 2011 indicating severe anxiety and being off work until after Christmas.

9.9.24. July 2012, GP entry noting he had an improvement in his mood.

9.9.25. 17 July 2012, GP entry noting he had a relapse following a reduction in his douse.

9.9.26. 30 July 2012, GP entry noting a sick note was issued on 27 July 2012. He had self-certified himself. He had damaged the ligaments in his ankle. He had a cast and was using crutches.

9.9.27. 7 August 2012, GP entry noting he had a cast on and since then had been in excruciating pain. It was keeping him awake at night. His wife stated the foot looked pink and well perfused.

9.9.28. 30 August 2012, GP entry noting he injured his left foot 6 weeks ago. He was in a cast. He had torn ligaments. He was getting extra stress from work. It was in the hands of a solicitor. He was stressed and anxious.

9.9.29. 19 September 2012, GP entry noting that his anxiety was worse since his road traffic accident. He had a whiplash injury. He was still having pain in his ankle.

9.9.30. January 2013, incompletely dated entry noting that he was still in pain and had tingling and burning sensation to the left ankle. He was taking Pregabalin but it was knocking him out. He had no response to the steroid injections. The diagnosis was nerve related neuropathic pain to the lateral aspect of the right ankle (I assume this should be left ankle).

9.9.31. 22 February 2013, GP entry noting that he had no response to increased dose of Pregabalin. He was due to be seen in the fracture clinic and by the psychologist. He was getting more anxious. He was prescribed Oromorph.

9.9.32. 11 April 2013, GP entry noting he had been turned down for ESA and was told he was fit for work. A sick note was issued for 3 months for a chronic regional pain syndrome and he was appealing the benefits.

9.9.33. April 2013, incompletely dated entry noting that he had no improvement in his pain and could not put his foot to the floor.

9.9.34. 16 July 2013, GP entry noting he had numbness in his left hand in the ulnar nerve distribution for 4 weeks. His pain in his leg was no better. His mood was no better. He was given pain medication.

9.9.35. 4 November 2013, GP entry noting he had an injury to his right leg 20 years ago and had pins in it initially. They were removed 15 years ago. His right ankle had a tendency to give way. It was worsening over the previous few months. It had given way 7 times that week. There was no obvious swelling or pain when he was examined. He was referred to Orthopaedics.

9.9.36. 9 January 2014, GP entry noting he had burning sensation to his foot. He had no relief from his medication. He had increased stress at home.

9.9.37. 7 October 2014, telephone encounter noting he was having his ankle fused on 29 October 2014. His wife was trying to get adult services involved for aids at home post-operatively due to mobility issues. He would not be able to weightbear. The wife had asked the district nurse about wheelchairs but was told he was not eligible because it was not long term.

9.9.38. 7 March 2015, noting that he required a sick note for a slipped disc and sciatica.

9.9.39. His records indicate that he was investigated for diabetes.

9.9.40. There are numerous consultations from the date of the index accident forward where he was supplied regular sick notes due to his ankle injury.

9.9.41. There are numerous further consultations in his records but no mention made of any ongoing pins and needles in his hands.

9.9.42. There are various entries pre-dating his index accident related to psychological issues.

9.9.43. I have had sight of copies of the GP's handwritten records but unfortunately some of the entries were not legible to me. I did, however, attempt to decipher them.

9.10. Updated GP Records

9.10.1. The computerised consultation entries run up to 7 December 2016.

9.10.2. The updated GP records note prescriptions for various pain relief and medications through his records.

9.10.3. 29 October 2015, letter from Consultant Pain Specialist noting that he had been reviewed without sight of the previous letter of 28 April 2015, which had not been typed. It was noted he had a left ankle injury in July 2012 and met the criteria for CRPS. After physiotherapy he went on to have an injection in his ankle. It was noted he had been involved in a road traffic accident and had not been able to work since. He had a

background of depression and lower back pain. He had tried various pharmacological agents to help with his mood and pain. He had been referred to Occupational Therapy with a view to assessing him for a spinal cord stimulator. He was unable to engage with the therapy due to the intensity of his pain. He had a right ankle arthroscopic fusion on 29 October 2014 for a long standing right ankle injury. It was explained that the possibility of a spinal cord stimulator could be reviewed, however, it was noted that on reviewing the notes this had already been explored and he was not going to be re-referred for this. he was advised to continue his pain medication.

9.10.4. 29 November 2015, letter from Pain Consultant when he was seen noting he had a very good result from his right ankle fusion. The doctor was unclear what medication he was taking and it was felt his compliance was variable. A dorsal column stimulator of the spine was discussed. It was felt that he was not at the stage where he would accept formal management options rather than anything curative.

9.10.5. 8 March 2016, GP entry noting a telephone encounter noting that since he had started at Longtech his pain had got worse. He was to retry Oxycodone.

9.10.6. There are various entries in his records related to management of his diabetes.

9.10.7. 2 September 2016, nurse assessment. His left foot was noted to have no deformity and his left dorsalis pedis pulse was present, which would indicate that the nurses pressed on his foot in order to feel the pulse. His pedal sensation was tested using monofilaments and was noted to be present. It was also tested on his toes. There is no mention made of any CRPS symptoms to his foot which prevented examination.

9.10.8. 3 October 2016, letter from Job Centre Plus noting that he met the eligibility for employment support allowance from 2 December 2015.

9.11. DWP Records

9.11.1. 16 January 2013, industrial injuries disablement benefits application form noting his index accident. It was noted he had severe pain with difficulty mobilising using crutches and a leg brace support. He needed assistance with some care tasks and was unable to walk long distances due to the pain using the crutches and tiredness. It was noted he was on medication for depression. He was unable to walk his dogs and unable to go out independently. He was unable to undertake activities such as shopping. The photocopied assessors form is poorly copied and difficult to assess. It would appear he was given a gross disability assessment of 35% which was reduced to a net figure of 27% due to the ankle injury and a 10% gross assessment reduced to 5% for depression.

9.11.2. 11 February 2013, completed limited capabilities for work questionnaire. It is signed by [redacted]. It is noted that on 19 July 2012 he had attended the hospital due to an accident at work and was diagnosed with a grade II sprain of his left ankle and was placed in a cast for 6 weeks. He then attended the fracture clinic and was referred to physiotherapy and given a walking boot. He was eventually diagnosed with a CRPS and was unable to weightbear on his left foot without crutches because of his pain. His condition had increased. He had developed depression and anxiety. It was noted *"the disability has left me unable to carry out normal living"*. It was noted his mobility was very limited and could only walk with 2 crutches and only take a few steps and then had to stop due to the

pain. The pain was noted to be unbearable most of the time. It was noted that the only time he did not have the pain was when the foot was not on the floor.

9.11.3. It is noted in response to question number 5 *"Using a pen or pencil can sometimes be difficulty. I have episodes when I can't grip a pen or pencil to write"*.

9.11.4. It is noted he has ongoing psychological symptoms of depression and anxiety, which it is noted he finds difficult to deal with.

9.11.5. There is a letter noting a decision was given on 8 April 2012, disallowing him from receiving employment support allowance as he did not meet the threshold for having limited capacity. I assume that this should decision should have been dated 8 April 2013, as the decision is dated 24 April 2013. It was noted [redacted] had requested a reconsideration of the decision. The original decision was reassessed and upheld.

9.11.6. 5 March 2013, Job Centre Plus letter noting that as a result of his industrial accident on 19 July 2012, he was considered 32% disabled from 1 November 2012 to 1 March 2014 because of loss of faculty and was due to receive payments.

9.11.7. 5 March 2013, a 32% disability was awarded from 1 November 2012 to 1 March 2014.

9.11.8. 6 March 2013, disability and carers application when his disabilities were noted to be CRPS, ankle damage, depression, diabetes. It was noted he had persistent pain following an injury to the ankle with the diagnosis being unclear. It was a possible chronic pain syndrome, possibly mechanical pain, and it was noted he had depression.

9.11.9. 18 March 2013 employment support allowance medical report form. The summary notes he had a problem with both of his ankles and took pain relief. He walked with 2 elbow crutches. He could walk around the house and climb stairs on his bottom. His walking was limited. He had no problems with sitting. He could wash and dress his upper half. He could make a cup of tea but could not carry it due to crutches. It was noted that when he was examined he had good movement and power in his upper and lower limbs, but he had pain on doing movement. He had anxiety and depression. The examination section noted that his left hip and knee bent fully. He was able to fully straighten his left knee. Power in his left leg was noted to be normal. Downward movements of the left ankle were normal. Upward movement of the left ankle was normal. The opinion was that the available evidence suggested significant functional impairment was unlikely. His left lower limb motion was noted showing symmetrical plantar flexion and dorsiflexion of the ankle with normal power.

9.11.10. 8 April 2013, decision for employment and support allowance. It was noted that the author had superseded the decision of the decision maker who awarded him the support allowance following medical assessment. It was felt that he was no longer assessed as having limited capacity for work and therefore limited capacity for work was not accepted from 8 April 2013 and he was not entitled to employment support allowance from that date.

9.11.11. 3 June 2013, employment and support allowance decision. It was noted that on 8 April 2013 a decision was made disallowing him from receiving allowance. It was requested the

decision was reconsidered and following reconsideration the decision was reversed and he was entitled to employment and support allowance.

9.11.12. 3 June 2013, typed entry noting that the author had spoken to [redacted] wife because [redacted] was nervous about talking on the phone. His condition was getting no better and his medication remained the same. Painkillers were not helped. He had been referred to psychology. He had to be accompanied everywhere not just due to his physical condition but due to his depression. He had become nearly housebound and was totally reliant on his wife for everything. He was claustrophobic and agitated in crowds. He had problems with self-care and lacked motivation. He got tearful and distressed.

9.11.13. 11 February 2015, decision form noting that he was given a 32% disability due to his industrial accident on 19 July 2014 (I assume this date is an error), with the percentage disability running from 8 February 2015 to 7 February 2018. On 11 February 2014, the assessment was noted to be 27% from 2 March 2014 to 7 February 2015.

9.12. Further DWP Records

9.12.1. The first section of the DWP records contains various clinical letters from Pain Physicians which have been reviewed elsewhere.

9.12.2. 4 May 2014, noting he was awarded disability living allowance at the higher rate for mobility and the highest rate for care. This was awarded until 6 August 2016.

9.12.3. 14 April 2016, completed personal independence payment claim form. In the health conditions it states *"CRPS, chronic regional pain syndrome left foot, severe depression,*

diabetes (Type I) undergoing tests (April 2016), high cholesterol". In the section relating to preparing foot it was noted that he is unable to prepare and cook meals for himself and it was all done by his wife. He could not physically carry things because of the use of 2 crutches. In question 4 it was noted he suffered with severe depression which had to be monitored. In question 5 it was noted he was unable to collect his medication and had to be monitored with his medication and was at risk due to his mental state. In question 6 it was noted he was unable to stand independently without crutches for his personal care. He had to use a bath board and had help to wash both his upper and lower body. In response to question 7 it was noted he had a bottle at hand downstairs for managing his toilet needs. For question 8 it was noted he was unable to prepare his clothes, which was done for him and he needed assistance pulling his trousers up and putting his shoes and socks on. In question 11 it was noted that he depression lead to him being at home every day. He suffered with anxiety. In question 14 in relation to mobility it was noted he could mobilise short distances around the home on crutches due to being unable to weightbear. He was at risk of falling because he was unsteady.

9.12.4. 27 May 2016, personal independence payment consultation report. It notes that he had osteoarthritis in his right ankle which he had had for a number of years before the right ankle was fused. It was noted his right ankle was fused and operated on a few years ago to straighten it and to keep it from collapsing. He was getting pain in his right ankle. With regards to what appears to be his left foot it was noted he had *"symptoms of pins and needles, burning, feels like the foot is in a bucket of hot water in left foot, no relief, can't be touched, sensitive (the wind on his foot will hurt him)"*. However, in his application form, signed and dated 14 May 2016, it is written in question 8 regarding dressing and

undressing, that he required *"assistance with pulling trousers up and fastening also putting socks and shoes on. Martin wears a slip on shoe/sandal on his left foot as he is unable to wear a full shoe due to his pain and is unable to have any pressure applied to the foot due to the sensitivity"*. The statement in the application form does not appear to fit together with the level of symptoms described in the assessment document. With regard to preparing food it was noted he required supervision or assistance to prepare or cook a simple meal. It was noted he would have to sit down to prepare a meal because he would require 2 crutches to maintain balance which was due to his extremely limited range of movement of both his ankles and significant pain in his left ankle. In the section regarding taking nutrition it was noted he needed an aid or appliance in order to take the nutrition or supervision, which was also the same for managing therapies or monitoring his health condition. With regard to washing and bathing it was noted he required assistance in order to get in or out of the bath or shower. With regard to managing his toilet needs it was assessed that he required assistance for this. With regard to dressing and undressing it was assessed that he required assistance to dress and undress his lower body. His verbal communication was noted to be normal as was his reading and understanding. With regard to engaging others, it was noted he needed prompting and also with regard to managing budget decisions it was the same. With regard to moving around, it was noted he could stand and then move more than 1 metre but no more than 20 metres either aided or unaided. Based on his future circumstances it was felt he should be reviewed in 3 years.

9.12.5. 19 July 2016, letter noting that he was awarded personal independence payment at the enhanced rate to help with daily needs and mobility.

9.12.6. The second section of the DWP records contains outlines of his personal independence payments.

9.12.7. The third section of the DWP records contains correspondence regarding disability living allowance.

9.12.8. The forth section of the DWP records relates to disability living allowance and personal independent payments up to 20 January 2017.

9.13. CCTV Camera Footage

9.13.1. There are a series of 4 cameras with most of the relevant footage being on camera 3.

9.13.2. On 19 July 2012, he is seen in what appears to be a warehouse. The concrete floor is uneven. He is seen walking across the floor. He turns to his left to gesture to someone. He then turns to his right. He then turns back to his left and jumps in the air landing on his left leg, which appears to invert somewhat and he falls to the ground. He lies on the ground for a few seconds and then sits up. He appears to remain there until some colleagues turn up. He manages eventually to get up and walks away with a minor limp and appears to be carrying on with his job.

9.13.3. From a further camera he is seen walking towards the camera with a relatively normal gait.

9.13.4. On camera 2 he is seen standing outside talking to colleagues equally weightbearing on both legs and walks around with a slight limp, after which point he sits down. A car is brought round and he seems to hobble significantly more getting up from sitting down getting into the car.

10. SUMMARY

10.1. [redacted] was at work on [redacted]. For some reason he jumped in the air and as he landed, he landed on roughened ground on the floor of the warehouse and inverted his left ankle falling to the ground.

10.2. He was investigated extensively by the Orthopaedic Surgeons and absolutely no structural abnormality was found to explain his symptoms.

10.3. He was subsequently diagnosed with a CRPS. His symptoms appeared to progressively get worse, taking into account the numerous letters his records together with the progression and deterioration in his symptoms between his first medical report with Mr Buckley and his second medical report where he turned up wearing a flip flop.

10.4. He has undergone a right ankle fusion.

10.5. He had a road traffic accident a couple of months after his index accident where he jarred his ankle again.

10.6. His examination is outlined above but was restricted due to the claimant not wanting me to touch his left foot.

11. OPINION

11.1. [redacted] sustained a relatively minor soft tissue injury to his left ankle.

12. PROGNOSIS

12.1. At the time I assessed him Mr Levick was about 4 years and 7 months following his index injury.

12.2. He stated that he had only suffered with psychiatric problems of depression and anxiety for only 6 months prior to his index accident. This is however significantly contradicted by his medical records which indicate a long and significant pasty history of psychological problems dating back many years prior to his index accident.

12.3. He sustained a minor soft tissue injury to his left ankle when it appeared to be that he was messing about at work. He inverted his left ankle. I would agree with Mr Buckley, that I would have expected his minor ankle sprain to have resolved and settled within 1 to 2 months of the date of the accident.

12.4. Mr Buckley felt that he would have required a month off work. I feel that 7 to 10 days would have been adequate generally given the injuries sustained and the fact that he wore boots at work to help support the ankle.

12.5. His ongoing complaints are outside the field of Orthopaedic surgery and are best prognosticated by Pain Physicians and Psychiatrist's.

12.6. His symptoms appear to have got progressively worse. His treating pain physician initially, in my interpretation of the medical records, did not appear to be entirely convinced of CRPS syndrome, noting that he was able to weightbear with little or no pain in a boot. His own DWP records in a claim form stated that he, himself, had no pain when

his foot was not on the floor. This, in my view, does not appear to be typical of CRPS pain and would be more consistent with mechanical pain. The trend looking through his records and previous reports are that his symptoms have gradually got worse.

12.7. In my experience of CRPS as an Orthopaedic Surgeon, normally the symptoms are at their worst early on and gradually tend to lessen to some degree over time, whereas [redacted] appears to be going the other way. His recent GP records note that his foot has been assessed by a nurse in relation to his diabetes and he had sensation testing of his foot and toes, together with palpation of his pulses. I am very surprised he tolerated this given the severity of his claimed pain to the degree that he would not even allow me to touch his foot, yet the entry in the records makes no mention of any difficulty with examination due to his apparent CRPS. I am sure this is something the Pain Expert can comment upon further. Furthermore, his application for PIP notes that he requires help when putting shoes and socks on and describes the type of shoes he would wear. However, when he was assessed for the PIP payment he informed his assessor that he could not tolerate anything touching the foot and in fact the wind would hurt his foot. When I assessed him he had marked complaints of pain when trousers were being passed over his foot, yet he is able to wear a flip flop with a large strap going over the dorsum of his foot. This does not seem compatible with his complaints.

12.8. All his previous medical reports note the fact that he injured his ankle whilst walking through the warehouse, where as this is obviously incorrect as he clearly jumps in the air before landing. He therefore appears to have concealed this fact to the experts that he has seen.

12.9. As I have outlined above, there are a number of contradictions in his history between what he has informed various professionals at one point compared to another stage following his accident. He stated to me that he could not allow anyone to even touch his foot due to the marked pain, yet he was able to wear a significant sized flip flop with strapping over the dorsum of his foot. He stated he could not put his foot to the ground, but was clearly able to put his foot to the ground, albeit not normally, at the time I examined.

12.10. I am not an expert in CRPS, but it would appear these contradictions and inconsistencies suggest a significant degree of non-organic overlay to his ongoing symptoms.

12.11. With regards to his occupation, absent the index accident, it is likely that both his right ankle and his low back problems would have restricted him in the open labour market in any event. He had back problems dating back to the mid 1980's when he had a wedge fracture. He had long periods of time off work in the 90's and then developed sciatic pain radiating to his right leg. Back pain tends to be recurrent in individuals who suffer with back symptoms and they tend to get recurrent episodes during their lifetime. These symptoms can worsen over time and is demonstrated in his own history of initially back pain progressing to back pain and sciatica. Absent the index accident, I feel he would have reached a point where he would have not been able to undertake heavy manual work due to his back pain, as this is a common restriction placed on individuals who have significant back and or leg pain.

12.12. He fractured his right ankle in the 1980's and it was noted in 2013 that his ankle was giving way. He was referred to his Orthopaedic Surgeons and underwent a fusion of his ankle in 2014. Given the symptoms leading up to his ankle fusion from around November

2013, I feel at that stage even absent his index accident, it was unlikely he would have been able to undertake heavy manual work due to the problems he was having with his ankle in addition to his back problems also. Following his fusion he continued to have pain in his right ankle as outlined in his DWP records in May 2016.

12.13. Therefore absent his index accident, I feel he would have been disadvantaged in the open labour market with regards to heavy manual work or occupations involving prolonged periods of standing and walking due to his pre-existing significant back and significant right ankle problems. As outlined above, I feel this disadvantage is likely to have commenced around November 2013 when he was having worsening problems of his right ankle and was referred to the Orthopaedic Surgeons.

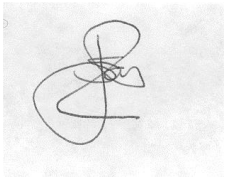
12.14. From an Orthopaedic perspective, I would not expect the accident to leave him at any disadvantage in the open labour market. I would not expect the accident to cause the acceleration or development of underlying degenerative changes.

DECLARATION

I understand my duty to the Court and have complied and will continue to comply with it.

I am aware of the requirements of Part 35 and Practice Direction 35, the Protocol for the Instruction of Experts to Give Evidence in Civil Claims and the practice direction on pre-action conduct. I have obtained Part 1 of the Certificate of Medical Reporting: the Bond Solon Civil Procedure Rules Expert Witness Certificate to evidence my understanding and compliance of the above requirements.

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.



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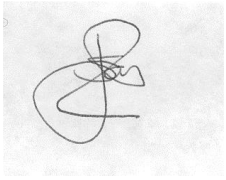
I confirm that I have verified with the claimant the facts as referred to in this report.

Signature:  Date: 02/03/2017