MR SANJIV JARI

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FIRST MEDICAL REPORT FOR THE COURT

NAME:

ADDRESS:

DATE OF BIRTH: (age)

OCCUPATION:

DATE OF ACCIDENT:

DATE OF EXAMINATION:

DATE OF REPORT:

AGENCY REFERENCE:

INSTRUCTIONS FROM:

REPORT PREPARED BY: Mr Sanjiv Jari

This is a condition and prognosis report on .....after interview and examination for the purpose of the report on ..... The report was prepared following instruction from .....

SUMMARY AND CONCLUSIONS

Mr …….. sustained an injury to the left foot when he went over an uneven paving stone. He appears to have sustained a soft tissue injury.

He has intermittent symptoms currently. I have recommended an MRI scan of his left foot.

I require sight of his physiotherapy records for the treatment that he stated he has had following his injury.

DOCUMENTS AVAILABLE

Letter of instruction from …… dated 12 October 2010.

Letter from …… Solicitors dated 7 October 2010.

Copy of hospital records.

Copy of GP records.

Copy of radiographs on cd-rom.

INSTRUCTIONS

The letter of instruction from ..... asks me to examine ..... and prepare a medical report. I have been asked to review the medical records. I have been instructed not to return the report until all the medical records have been provided to me.

METHODOLOGY

This report is intended to be entirely independent and is prepared on the basis of instructions received from ..... during their interview, observations and physical examinations performed by myself in my consulting room on ..... The client was unaccompanied. There were no communication difficulties. There were no tests or experiments conducted.

SUMMARY CV

I, Mr Sanjiv Jari, am a Consultant Trauma and Orthopaedic Surgeon at Hope Hospital in Salford and was appointed in 2001. I am also an Honorary Clinical 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 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.B.Ch.B, FRCS (Eng), FRCS (Tr & Orth) and I have a Sports Medicine Fellowship Diploma from the University of Indiana, in the USA.

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. .....is a 26 year old gentleman who informs me that on ..... in the evening he was walking his dogs with his mother. He was walking along a path when he states there was an uneven paving slab. He stepped onto this and then went over on his left foot. He then fell to the ground.

1.2. He had immediate pain in his left foot and his foot swelled up. He was helped up but he was unable to fully weight bear. He rested things overnight but the next day his foot was even worse. He went to Preston Hospital where he was seen and assessed. He had x-rays taken and was told he had fractured his foot.

1.3. He was put in a cast and was given crutches. He was in the cast for 4 or 5 weeks and was using the crutches, non-weight bearing for that period of time.

1.4. When he came out of the cast he was sent for physiotherapy which helped his symptoms to some degree.

2. CURRENT SITUATION FROM CLIENT

2.1. He states that overall his foot has improved significantly. His acute pain had more or less settled within 8 weeks of the accident.

2.2. He states that on 4 occasions since his accident he has had episodes of "flare ups". He states that while he is walking barefoot, very occasionally he will feel a pop in his foot and then develop acute pain for 2 or 3 days. His symptoms then settle.

2.3. The last time this occurred was 6 to 8 weeks ago. It has only occurred on 4 occasions since the accident.

3. OCCUPATION FROM CLIENT

3.1. At the time of the accident he was a …… working 16 to 40 hours a week. He was off work for 5 weeks following the accident. He then returned back to his normal occupational duties.

3.2. Currently he works as a night time receptionist at a hotel.

4. SOCIAL HISTORY FROM CLIENT

4.1. ..... is single. He has no children. He lives with his parents.

4.2. Prior to the accident he did not do any domestic activities.

4.3. Following the accident he was able to wash and dress himself without assistance.

4.4. His sleep was disturbed for about 2 weeks.

4.5. He was unable to drive for 5 to 6 weeks following the accident.

5. RECREATIONAL ACTIVITIES FROM CLIENT

5.1. Prior to the accident he used to ride a horse 4 or 5 times a week. He used to walk his dogs twice a day.

5.2. He returned to dog walking after his cast came off and slowly built up the distance he walked over the first month or so.

5.3. He has not returned to horse riding. He did try on a couple of occasions but found that the stirrup caused pain in his foot. He is trying to re-start again and has a horse riding lesson today.

6. PAST MEDICAL HISTORY FROM CLIENT

6.1. He has had no previous problems with his foot.

6.2. He has had no other accidents or claims.

6.3. He has suffered with depression for many years.

7. PSYCHOLOGICAL STATUS FROM CLIENT

7.1. He did not develop any psychological symptoms following the accident.

8. EXAMINATION

8.1. ..... was a well looking gentleman who walked with a normal gait. His sitting and standing spinal posture were poor with slumping of the spine. He informed me he was 5 feet and 10 inches tall and weighed about 13 stones.

8.2. Feet

8.2.1. He stood with mobile flat feet bilaterally. He was able to hop on each leg without any difficulty. He was able to single heel raise without pain. He complained of a strange sensation on the dorsum of his left foot when single heel raising. He had no tenderness on palpating his metatarsals, phalangeals, midtarsal, ankle joint or heel. He had no features of chronic regional pain syndrome. He had no swelling in his foot.

8.2.2. He had painless, symmetrical subtalar motion, ankle joint motion and midtarsal motion. He had normal power in all the muscles crossing his ankle. He had no neurovascular deficit in his foot.

9. REVIEW OF RECORDS

9.1. A&E records

9.2. GP Records

9.2.1.

9.3. Review of Radiographs

10. SUMMARY

10.1. ..... is a 26 year old gentleman who inverted his left foot on 25th June 2009 and injured his foot. He states he was treated as a fracture and was in a cast for a number of weeks. His hospital records indicate that he did not attend for further follow up.

10.2. He complains of 3 to 4 episodes of a "popping" sensation in his foot followed by pain for 2 to 3 days which occurs very intermittently.

10.3. His examination is outlined above and was normal.

11. OPINION

11.1. ..... appears to have sustained a soft tissue injury to his left foot.

12. PROGNOSIS

12.1. ..... is now about 1 year and 4 months following his injury.

12.2. He states that his acute symptoms settled within 8 weeks which I would accept as being reasonable and directly attributable to the accident. His symptoms appear to be of a soft

tissue type injury as his initial x-rays do not demonstrate any bony injury. His hospital records indicate that he did not attend for follow up towards the latter end of his care.

12.3. In view of his ongoing symptoms I would recommend he has an MRI scan of his left foot and I will prepare a supplementary report once I have had sight of this and the radiologist's report.

12.4. I require sight of his physiotherapy records for the treatment he stated he has had following his injury.

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, this protocol and the practice direction on pre-action conduct.

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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