PHYSIOTHERAPY REPORT

Neurolgical

Concerning

of

Date of Birth:	xxxxxxxxx
Date of Accident:	xxxxxxxxx
Date of Examinations:	18.04.2019
Date of Report:	June 2019

Prepared by:

Ms Anna Wilkinson. MSc. MCSP. MHPC.
Chartered and Health and Care Professions Council Registered Physiotherapist
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Prepared for the Court

Instructing Solicitors:

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1.0 INTRODUCTION

1.1 The White House Medico-Legal Services - consists of a Multi-Disciplinary Team of Consultant and Senior Nurses, Chartered and Health and Care Professions Council Registered Senior Physiotherapists, Consultant Occupational Therapists each specialising in their own particular area. Cases covered include adults and children severely disabled through road traffic accidents or by medical negligence resulting in such injuries as head injuries, spinal injuries and cerebral palsy as well as sporting and industrial accidents and straightforward orthopaedic accidents resulting in whiplash, back injuries, amputation, fractures and soft tissue injuries besides simple tripping and slipping accidents. Professional Negligence Reports are also prepared on Nursing and Physiotherapy Issues. Cases are undertaken on behalf of the Claimant, Defendant and as Single Joint Expert.

1.2 The Expert xxxxxxxx is a Senior Chartered and Health and Care Professions Council Registered Physiotherapist with a special interest in rehabilitation of neurological and orthopaedic injuries. She is Partner of the White House Medico-Legal Services and Managing Director of More Rehab Ltd, providing multi-disciplinary rehabilitation for adults & children with neurological, complex orthopaedic & respiratory Conditions. Her experience has focused on Rehabilitation of patients with Orthopaedic and Neurological Injuries. She is a Member of the Medico-Legal Association of Physiotherapists (MLACP), a 1st Tier Expert Member of the Association of Personal Injury Lawyers (APIL), the Organisation of Chartered Physiotherapists in Private Practice (Physio First), the Association of Chartered Physiotherapists Interested in Neurology (ACPIN) and the Aquatic Therapy Association of Chartered Physiotherapists (ATACP). She has been working in the Medico-Legal field for fourteen years.

Her Curriculum Vitae is attached.

1.3 Instructions

I have been instructed by xxxxxxx Solicitors of Sheffield, who act as Solicitors for the Claimant, to prepare a Physiotherapy Report for the Court concerning xx of xxxxxxxxwith regard to injuries he sustained in a road traffic accident on xxxxxxxx. xxxx has residual deficits as a result of the injury. Current and Future Physiotherapy and Rehabilitation Requirements and Costs are detailed in this Report.

The contents of this Report are true to the best of my knowledge and belief. They are based on my understanding of the Claimant's needs following my assessment, observations and examination of the Claimant and consideration of the Medical Reports and documentation available to me at the time of preparing this Report. No responsibility can be accepted for injury or damage arising from the use of any recommended equipment or from following any course of action stated in this Report.

Mr McMahon's details are: -

Date of Birth:	xxxxxx
Date of Accident:	xxxxxx
Date of Examination:	xxxxxxx
Place of Examination:	xxxxxxx Clinic, Beckett Road, Doncaster

1.4 Synopsis

I have assessed xxxxxx and reviewed the evidence available to prepare a physiotherapy report detailing physiotherapy requirements as a result of the injuries sustained on 1st February 2016.

1.5 Summary of My Conclusions

xxxxxxxxx has a complex presentation with vestibular features. He needs a programme of rehabilitation from a multi-disciplinary team including physiotherapy to optimise his physical management and then a lifelong maintenance programme with a daily regime in place to maintain his physical activity.

2.0 HISTORY

2.1 Issues to be addressed

I have been asked to address:

- Any relevant pre-morbid conditions;
- Provide a "top to toe" summary of the Claimant's injuries in your field of expertise including the nature, extent and severity, including the Claimant's current condition;
- The impact upon the Claimant's ability to engage in employment, social events and leisure activities;
- An assessment of the physiotherapy treatment the Claimant has received to date and whether you consider this support to be reasonable and appropriate;
- Provide a summary of the relevant aids and equipment that the Claimant has purchased to date and whether you support the purchase as being both reasonable and beneficial;
- Whether you would recommend specific physiotherapy, hydrotherapy and / or other therapies / input to maximise the Claimant's functioning and / or general recovery, or any particular aids / equipment that you would recommend to benefit the Claimant and the costings for these on a private basis (if you are able to say) . if you cannot provide costs information, please would you confirm if you recommend a specific assessment in relation to those therapies recommended;
- The prognosis for the Claimant, if it is possible to say at this time. If it is not yet possible, please state when you would like to see the Claimant for review;
- Whether you would recommend the Claimant is assessed by any other experts in any other fields;
- Any other issues that you feel are relevant.

2.2 Injuries and Disabilities Sustained

- Severe subarachnoid haemorrhage;
- Bilateral frontal contusions;
- Bilateral skull fracture;
- Abrasions to the right posterior chest, both right and left knee and hand swelling.

2.3 Details of the Accident and Subsequent Treatment and Medical Care

xxxxxxxxxxx reported to me that he remembers going to work on the day of the accident and his next memory after that is waking up in the xxxxxxxxxxx Infirmary. He does not recall any details of the accident. The details below have been obtained from the evidence.

At the time of the accident, the Claimant was working for a company called xxxxxxxxx. He worked in a physically demanding role assisting with the installation of storage systems and mezzanine floors. On the day of the accident, he was installing some stacking systems on a storage section. He was instructed to replace some side rails on level 4 of the building he was working in. He went to step over the side of the shuttle system and lost his footing. He fell approximately 16 metres to the ground. It was reported that he lost consciousness.

An ambulance attended the scene and it was reported that his GCS was 6/15. He was taken to xxxxxxxx Hospital in xxxxxxxx. On initial examination, his injuries were noted to be a severe subarachnoid haemorrhage, bilateral frontal contusions, bilateral skull fracture and multiple abrasions.

The Claimant was then transferred to the xxxxxxx Centre for Neurology and Neurosurgery and due to severity the team proceeded to a decompressive craniotomy on 2nd February 2016.

Later that day, the Claimant had further scans. Whilst the chest scans were reported as unremarkable, the CT head showed parenchymal contusions with left frontal and temporal lobes anteriorly with minimal herniation of the brain tissue at the site of the craniotomy. He was ventilated and sedated.

Management over the following week is well detailed elsewhere, for the purposes of this report it is suffice to say that he remained unwell and continued to require neurosurgical management. This included the insertion of an EVD. An initial attempt at weaning on the 15th February was unsuccessful. A tracheostomy was inserted on the 19th February 2016. The EVD was removed on the 24th February 2016. Sedation wean was gradual from the 18th February and it was noted that by the 26th February he was completely off all sedation. On

the 26th February there is a note that he was flexing to pain. A plan was made that Mr Mr would be transferred to xxxxxxx when a bed was available.

xxxxxxwas transferred to the High Dependency Unit at xxxxxx on the 3rd March 2016. He was admitted with a recorded GCS score of 9/15. The following day, he started eye opening and was tracking staff in the room. He started to move his left arm and grip with his right hand by the 6th March, with improved head control.

He had a helmet fitting and a PRAFO boot fitting on the 7th March.

xxxxxxand his family report that they remember this as the time he "started to come round". His GCS score continued to improve and he became more restless with increasing movements. By the 26th March, he was transferred onto a ward. He started getting out of bed after his helmet was delivered on the 4th April. He had a PEG feeding tube inserted on the 7th April 2016. By this time, he was mobile. His swallow and communication continued to improve.

He was transferred to xxxxxxon the 18th April 2016 for further rehabilitation. He self-discharged on the 19th April and returned home to live with his family. He reported to me that he felt he was ready to go home and the rehabilitation he was receiving had reduced. He was referred to speech and language therapy in the community.

He presented to xxxxxxAccident and Emergency department on the 28th April with an episode of dizziness. He was admitted to monitor for infection and sepsis. He was discharged on the 1st May. He was reviewed on the 3rd May, no further problems were noted. The PEG tube was removed on the 11th May 2016.

There continued to be speech and language therapy work in the community. He was then referred to the outreach team with an initial appointment for the 5th July 2016.

He was referred to a private rehabilitation team in 2016. I have detailed this further below.

In 2018, he was admitted to xxxxxxand sedated for 24 hours due to multiple seizures. His seizures are now more stable and his medication is under regular review. He currently has 6 seizures per year but the aim is for him to be seizure free.

It was reported to me that has been discharged from all NHS care. He reports that he only has private input now and he sees Dr Pxxxxxxxxxxxxy in xxxxxxand an Epilepsy Consultant at the xxxxxxHospital in xxxxxx.

2.4 Residual Effects of the Medical Insult

a) Physical Effects

- Pain
    - Bilateral leg pain – it was reported to me that his legs ache when he is sat. He says that he gets a sharp pain in his legs when he stands up.
    - Back pain – he reports that he gets a 'catching' pain in his back as he stands.
    - Headaches – these are of variable frequency and he uses co-codamol to break through the pain.
- He has reduced sensation in his hands – it was reported to me that he can't tell hot and cold and has reduced grip bilaterally.
- He reports that there is bilateral leg weakness – he told me that he feels they are both the same but both weaker than they were before.
- He reports reduced balance – he says his walking is ok but if he jumps he is wobbly. If he has been sat for a while and then goes to get up, he has to steady himself.
- Dizziness – he reports that this is an ongoing issue. He gets blurred vision with this. He reports that there is no pattern with this; he can be sat or moving when it comes on.
- He reports that he gets hot and short of breath at times – this is sometimes at the same time as the dizziness.

b) Cognitive and Emotional Effects

xxxxxxhas significant cognitive and psychological sequalae. I refer to the reports of Dr Priestley for further details.

2.5 Previous Physiotherapy and Hydrotherapy

xxxxxxhad physiotherapy as an inpatient.

After his discharge, he was referred to Reach Rehabilitation by the parties involved in November 2016.

During my assessment, he was unable to say what he felt was better / had improved with physiotherapy. He said he could walk and can still walk.

He reported that the physiotherapist at the time of my assessment was xxxxxxand she saw him either at home or at the gym. His joint case managers were xxxxxxand xxxxxx. He is seen by the physiotherapist once a fortnight and by a rehabilitation assistant 2-3 times a week to complete the programme.

3.0 MY INVESTIGATION

3.1 Sources of Evidence Considered:

My Report has been compiled following an interview lasting 2.5 hours involving assessment, examination and observation of xxxxxxand detailed discussion with him and his father's partner, when they came to see me at my clinic in xxxxxx.

My information in preparing this Report has been drawn from the history of events as related to me by the Claimant and perusal of the Medical Reports and Hospital Notes and documentation.

3.2 Documentation Considered

a) on behalf of the Claimant

Medical report of xxxxxx, Consultant Neuropsychologist, dated xxxxxx

Second medical report of
Medical report of

b) Treatment and Medical Records

GP records from
Hospital records from
Updated hospital records
Hospital records from
Hospital records from
Patient record from September 2016
Hospital records from Hospital received February 2017
Hospital records received January 2019
Updated GP records from received January 2019
Physiotherapy report dated 20 July 2018
Physiotherapy Update Letter dated 3 December 2018
Physiotherapy plan dated 15 January 2019

4.0 GENERAL ASSESSMENT

4.1 General Appearance and General Health

xxxxxxis 6'3" tall and reports that he used to weigh 15-16 stone and is now about 13 stone.

4.2 General Practitioner and Current Medication

xxxxxxcurrently has the following medication:

- Midazolam
- Buccolam (emergency use only)
- Keppra
- Lamotrigine
- Phenytoin (dosage reviewed every 8 weeks)
- Sertraline

His father's partner puts all his medication into a nomad and he administers them from there.

4.3 Accommodation and Social situation

xxxxxxis currently living in rented accommodation. It is a mid-terraced house and has two bedrooms. There is a toilet upstairs and downstairs. There is a bath in the bathroom and he told me that he like to have a bath. He has a lounge and a kitchen.

He is supported by his father and his father's partner and a support worker who does 2 shifts of 2 hours a week. She works with him on speech and language work and helps with money management.

4.4 Activities of Daily Living and Personal Care

xxxxxxhas an adapted independence with his daily routine. He does not see his family every day but does send them messages on the days he doesn't see them. He walks to the shops for things he needs and he reports that this helps his legs to get stronger.

4.5 Mobility

a) Self-Mobility

He is independently mobile. He reports that he doesn't need to rest and he told me that his walking distance was unlimited. He told me that he was ok walking on uneven surfaces and up and down hills.

b) Vehicular mobility

He is a non-driver. He is able to get in and out of a car independently although he did tell me it was a squash to get his legs in!

4.6 Leisure Activities

Prior to the accident, xxxxxxworked full time. He enjoyed rugby, going out on his moped and cycling on his mountain bike. He liked going to the dog racing and ice skating.

He reports that he goes to the gym. He goes on the treadmill and does upper body weights. He told me that he did not do any leg weights.

It was reported to me that he enjoys swimming and he has been with his father to the xxxxxx and also to the xxxxxx baths. I was told that the physiotherapist and an assistant took him to baths the week of my assessment and the family were told that he needed two to take him safely.

He enjoys playing darts and dominoes and plays in a league. He plays at least every week if not more often. He enjoys karaoke and music. He goes to the pub and the dog racing. He has been bowling occasionally.

He told me that he is keen to get a job and work in the future. He was not sure what we would do. He told me that he might try racquet sports in the future such as tennis or badminton. He told me he would quite like to ice skate or ski but he was worried about falling over.

5.0 PHYSICAL EXAMINATION

5.1 Range of Movement and Muscle Power

Range of Movement Tests (ROM) are measured by a series of exercises at each peripheral joint or spinal level taken actively by the patient or passively by the Physiotherapist. (EOR) indicates end of range. Muscle Power Tests (MP) are a resisted exercise test to prove the strength of each muscle group tested and are measured on the Oxford Scale. This is a numerical record used to chart the voluntary responses of each muscle group tested if applicable

0. No contraction.
1. Flicker but no actual movement.
2. Contraction producing movement when gravity is eliminated
3. Contraction against the force of gravity
4. Contraction against gravity and some resistance
5. Normal strength

5.2 Posture

Xxxxxx can maintain a good neutral posture independently. He was able to adjust and adapt his posture.

5.2.1 Cervical Spine

He has full range of movement and power in the neck. He told me and demonstrated to me that he likes to crack his neck.

5.2.2 Thoracic and Lumbar Spine

Flexion	In sitting - full range In standing – reaches to mid shin, takes effort, reports doesn't like moving forwards	
Extension	In sitting and standing – good, full range	
	Right	**Left**
Rotation	½ active range, full range of movement with 'hands on' but reports feels hot.	½ range actively, full range of movement with 'hands on' but reports feels hot.
Flexion	Full range	Full range

Rotation bilaterally caused pain in the posterior upper quadrant.

5.3 Upper Limbs

There was full range of movement and power in all arm joints. There was some reduced power in arm movements through range or if his core wasn't stabilised. That means for example, if he was perched on the edge of the plinth and reached out of his immediate base of support and then resisted. This presentation was worse on the left.

5.4 Lower Limbs

Please see below. There was full range available passively but not actively. Xxxxxx did complain of muscle stretch at the end of range in flexion of both lower limbs and into dorsiflexion with a straight knee. With a stretch, this pain quickly reduced.

5.5 Activity Tests

Sit to stand (after he had been sat for some time) presented as effortful and unco-ordinated.

During the sitting to lying transfer, he utilised neck extension to lift his legs on to the bed. He told me that he was unable to get his knees to go flat in lying. This was possible with minimal facilitation.

He was able to bend his right leg fully whilst his foot was on the bed but found it difficult to lift his foot off the bed. He was able to straighten the leg back down to the bed with little difficulty. This movement was ataxic.

Flexing the left leg was a slow and jerky movement. He was able to bring the left hip to 45° and could not then go any further. I was unable to ascertain why – xxxxxx was saying 'yes' to both pain and weakness (and other options around these words). He was able to fully straighten the knee back down although there was some reduced fluidity.

He was able to do a straight leg raise with both legs whilst in semi-recumbent position. With both legs, the ankle was held in plantar flexion. The knee was 2° off full extension with a straight leg lift bilaterally. The movement was better with the left leg compared to the right.

He was able to move to a crook lying position although it was slow. He was able to lift to a bridge about 4" off the bed. Whilst he was doing this movement there was 'flapping' in his hands.

From a crook lying position, he was able to drop the left knee out to the side with good control. The right leg drop was stiffer with reduced range and there was reduced stability offered on the left side.

During lying to sitting, he moved his legs together in a locked position. He needed his upper limbs to complete this transfer.

He was able to take his shoes off independently and put them back on and do his laces up independently. There were no difficulties during these tasks.

He was able to maintain his sitting balance on a sitfit (wobble cushion). He was able to lift his arms up in the air with no increased unsteadiness. He was able to lift alternate lower limbs although this made him a little unsteady and the lifting of his legs was unco-ordinated. He was able to maintain his sitting balance whilst lifting the opposite arm and leg although there was shaking in the limbs as he was moving.

He declined to complete a 360˚ turn as part of balance testing due to "his head". He was able to turn 180˚ in 4 steps to both sides. He complained of increased eye and dizziness symptoms whilst he was doing this.

He was able to do a single leg stand but leant onto the wall as he was worried about falling.

He was able to do a single leg stand with one finger on my hand. He was able to maintain this for 8 seconds on each side and then became panicky and put his foot to the floor.

He was able to complete both heel raises and toe raises with good control on both sides.

Moving his hand from his nose to a pen was worse with his right hand. He was able to complete but with less control with speed.

He was independent with gait with an altered pattern – please see video.

He was able to squat to half range with good control. He was unsteady with repeated squats but had good control of this.

He was able to lunge with both legs forward to about half range to the floor. He then proceeded to keep going and lower his knee to the floor and push himself back up again without using his upper limbs. Once his knee was placed on the floor he was able to hold this position. It was effortful for him to push back up from the floor but he did manage this.

5.6 Muscle Tone

This appears when watching him move to be increased but with passive movements during my assessment, was not increased. It looks to increase with effort.

5.7 Sensation Tests

I was unable to gain reliable responses to sensory testing.

5.8 Vestibular tests

Eyes to left and right caused increased blurred vision with nystagmus and reduced tracking. He reports he does not feel comfortable doing this movement and felt a bit hot.

Following a pen to the left and right and focussing on a pen then on picture on the wall behind both increased his symptoms.

Focussing on an object and then turning his head (eyes still) increased his symptoms.

6.0 PHYSIOTHERAPY RECOMMENDATIONS

6.1 Future Aims

Xxxxxx requires some further rehabilitation. As a priority, he requires vestibular input from a specialist physiotherapist. There is some further work on his control of movement and high level movements to complete.

After a further 12 months, he will reach the stage that he can continue a physical activity programme with ongoing training effects. At this stage, he will require a maintenance level from a physiotherapist.

Recommended Programme of Rehabilitation

Phase I – Ongoing Programme

The initial programme should aim to

- Continue to work on strength through range
- Continue to work on movement patterns during activity and gait
- To continue to progress his gym programme.

- To explore alternative leisure options including cycling.
- Vestibular assessment and treatment

Phase II -

By this time xxxxxx physical condition will be stable and likely to have plateau'd although there may be some ongoing training effects. He will have an established routine to manage his physical activity. He will need ongoing physiotherapy to review the programme, to monitor his symptoms and leisure programmes. He will also need assistance from his physiotherapist to make informed decisions about replacing equipment (exercise equipment) and progressing or changes to his gym and leisure programmes. His physiotherapist will also monitor for deteriorations for example in tone or range of movement and assist management of any secondary complications. It is important that these are picked up and addressed in a timely manner in order minimise the severity or impact on his function and quality of life.

6.2 Physiotherapy Treatment Requirements

Physiotherapy Treatment may at times be available on the National Health Service but tends to be limited and not likely to meet xxxxxx needs at this stage. Indeed, he has not been offered NHS physiotherapy for some time. Provision should be made for sessions to continue in the Private Sector as funding in the Health Service is now so limited.

It is my opinion that xxxxxx will continue to benefit from a local gym and pool access on a lifelong basis.

My recommendations for future requirements for Formal Physiotherapy Treatment and Aquatic Therapy Treatment and costings have been outlined below. I have recommended treatment based on my findings at assessment.

6.3 Recommended Physiotherapy Programme of Treatment

I recommend:

Immediate Programme -

Phase I

Formal Physiotherapy Treatment on a regular basis for a period of a year. I recommend he continues an average of fortnightly sessions. This should include vestibular sessions. The aim should be that his programme is supported by his support worker in the medium term as their hours increase. Input from the physiotherapist can gradually reduce throughout the year.

Phase II – ongoing maintenance programme

I recommend that xxxxxx has 12 sessions per year for 5 years for ongoing maintenance of his programme, training of carers and reviewing and updating equipment. I suggest that 4 of these sessions will need to be at the gym to assess the programme in that environment and the others could take place at clinic. After this time, I suggest that he will need 8 sessions per year for the rest of his life.

Musculo-skeletal Therapy

I advise that one period of six sessions every 2 years after the Phase I are allowed for musculoskeletal injuries which may occur. These can be carried out at a local clinic.

Gym membership

Xxxxxx will need to engage in a regular exercise programme in a gym environment to optimise and maintain his physical abilities.

MDT meetings

These are vital to ensure that the rehabilitation programme maintains efficiency and efficacy. They will gradually reduce in frequency as the programme goes on.

6.4 Home Programme

Carers should be taught to support him with the physical activity and exercise programme. He should have an ongoing programme which incorporates aspects of vestibular work, stretches, strengthening, balance and core stability work. The physiotherapist will then oversee the home and gym programme and support xxxxxx and his support workers to complete this.

6.5 Recommended Physiotherapy Treatment Costs

First Year

26 sessions @ £85 per session = … **Phase I one-off £2,210.00**

Travel will be in addition. Although **xxxxxx** can attend a local clinic, **xxxxxx** has been treating for some time now and this therapeutic relationship will be valuable at this stage. There will need to be input from another professional regarding vestibular treatment.

Phase II - Ongoing Maintenance Physiotherapy Treatment

12 x 1 hour sessions per year in clinic @ £85 = … **for 5 years £5,100.00**

8 x 1 hour sessions per year in clinic @ £85 = … **annually £680.00**

I suggest 4 sessions per year will need to be at the local gym. I suggest an allowance of £30 per session for travel.

Musculo-skeletal Therapy

1 episode of sessions per year @ £45 for assessment and £35 for treatment sessions =

1 assessment sessions @ £45.00 = £45.00

5 treatment sessions @ £40.00 = £200.00

… **annually £122.50**

MDT meetings

Frequency may be further advised by the Care Expert. It is typical, in my experience, to have twice yearly for the next 2 years and then annually thereafter. Meeting for clients such as xxxxxx may be up to 2 hours.

Hourly attendance rate @ £85 per hour, travel may be included depending on where they are to be held.

2 hours @ £80 = up to £160 per meeting plus up to £50 travel.

2 meetings for 2 years @ £210 per meeting = … **one-off cost £840.00**

Ongoing MDT meetings @ £210 = … **annually £210.00**

Gym membership

Monthly gym membership @ £27 per month

… **annual cost £324.00**

7.0 FUTURE TREATMENT AIDS AND EQUIPMENT RECOMMENDED

Aids and Equipment recommended in this Report are examples of types and models available at the present time, together with the approximate purchase price. It should be noted that recommendations are not an endorsement of a particular manufacturer or retail company, but are an example of what, in the writers view, are most suitable for the Claimant from what is currently available.

Such equipment should be carefully selected in consultation with xxxxxx Treating Physiotherapist and Occupational Therapist to make certain that it meets the required goals.

7.1 Equipment Recommended

A small amount of equipment is recommended for xxxxxx to be able to continue exercising at home in between physiotherapy and gym sessions.

Therapy Equipment:

- Sitfit – for postural stability work
- Strap on weights – for upper limb strengthening

7.2 Recommended Equipment Costs

ITEM	AVAILABLE FROM	REPLACEMENT	PURCHASE PRICE
Sitfit	Various suppliers	4 years	**£33.00**
Strap on weights (adjustable)	Various suppliers	6 years	**£45.00**

8.0 CONCLUSION

Xxxxxx has residual deficits which affect his physical performance. It is important that he has the support of a physiotherapist to optimise and then maintain his physical movement patterns. He will be at risk of developing secondary problems if his movement is not optimised. It is imperative that he has sufficient vestibular treatment to address his vestibular compromise – this is severely limiting his movement and rehabilitation potential. He will need lifelong access to a gym and pool for exercise to ensure that he can exercise in a safe way in order to work on particular aspects of his programme.

APPENDIX ONE - RATIONALE OF PHYSIOTHERAPY TREATMENT

Physiotherapy treatment consists of three modalities of treatment:

- Formal Physiotherapy Treatment.
- Aquatic Therapy Treatment.
- Lessons in Riding for the Disabled or Hippotherapy

10.1 Formal Physiotherapy Treatment consists largely of Manual Therapy and Electrotherapy Treatment. Manual Therapy involves different techniques of exercise therapy, stretching techniques, active and passive movements, mobilisations and manipulative procedures, correct positioning, postural awareness and its correction, aromatherapy and acupuncture. A number of these techniques are relevant to Mr Walter's condition.

Several of these treatment techniques are crucial to the reconstruction of any degree of life for the disabled. After traumatic and neurological damage, affected muscles, joints and ligaments become stiffened in unnatural positions and wasted. Joints become susceptible to pathological fractures. It is important that peripheral circulation is maintained by activities and exercise, pressure sores and contractures prevented. Postural positioning to improve head, sitting and balance control, active and passive movements, resisted muscle work and stretching techniques to all four limbs, the head and trunk are all important to be carried out daily as a Home Exercise Programme. The Treating Physiotherapist must ensure that when the exercise programme is taught to Carers the correct lifting and handling techniques and postural awareness is always emphasised.

10.2 Aquatic Therapy Treatment is a physical scientific treatment whereby patients use water as a medium. This treatment plays an important role in the rehabilitation of the severely disabled. Treatment should be given and monitored by a Chartered and Health and Care Professions Council Registered Physiotherapist with specialised experience in this field. Not every Physiotherapist is qualified in Aquatic Therapy. It is possible by certain water-based exercise techniques to reduce muscle tightness and to gain increased active mobility. I do not consider Mr McMahon requires this service. He should continue to exercise in water in a leisure pool.

10.3 Lessons in Riding for the Disabled or Hippotherapy gives severely disabled people the means of enjoying an outdoor activity and helps to improve balance and strengthen back muscles. Hippotherapy involves the use of a horse as a Physiotherapy Treatment Modality. This activity is not recommended for Mr McMahon at this time. He told me that he did not want to try horse riding at the time of my assessment.

The Treating Physiotherapist must ensure that when an exercise programme is shown to the Client and Carers the correct lifting and handling techniques and postural awareness is always emphasised.

APPENDIX TWO - EXPLANATION OF COSTS

FEE STRUCTURE

Fees for Private Physiotherapy Treatment can no longer be recommended by our professional bodies the Chartered Society of Physiotherapy (i.e., CSP) or the Organisation of Chartered Physiotherapists in Private Practice (i.e., OCPPP). There is variance in figures. I have researched what is available locally and what the current physiotherapist charges and considered these aspects in recommending a cost.

RECOMMENDED EQUIPMENT

Certain items may have Value Added Tax Exemption if they are being purchased for a disabled person. VAT Exemption Forms have to be signed by a Chartered and Health and Care Professions Council Registered Physiotherapist or a Doctor before purchase.

Equipment Companies frequently close down or amalgamate leading to change of name or reduced availability of equipment. At the time of writing this Report details of equipment and suppliers are correct although more superior products may very quickly replace certain items.

Some of the equipment will become obsolete and with wear and tear will need replacing regularly. Dividing the cost by the expected life of the item should annualise replacement costs and an appropriate multiplier should be applied. Carriage costs and VAT have not been included in the majority of the costs itemised in the report.

DECLARATION

I understand that my overriding duty is to assist the Court on matters within my expertise and that this duty overrides any obligation to Irwin Mitchell Solicitors or their clients. I confirm that I complied with that duty and will continue to do so. I am aware of the requirements set out in Part 35 of the Civil Procedure Rules and the accompanying Practice Direction and the Protocol for Instruction of Experts to Give Evidence in Civil Claims.

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 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.

Anna Wilkinson MSc. MCSP. MHPC. MEWI.
Consultant Chartered and Health and Care Professions Council Registered Physiotherapist.
Partner of The White House Medico-Legal Services

Ref: AJW/DGW/C.

CURRICULUM VITAE

ANNA WILKINSON MSc. MCSP, MHPC

CHARTERED SENIOR PHYSIOTHERAPIST (Member HPC)
CONSULTANT CHARTERED AND HEALTH AND CARE PROFESSIONS COUNCIL REGISTERED PHYSIOTHERAPIST
PARTNER OF THE WHITE HOUSE MEDICO-LEGAL SERVICES.
MANGING DIRECTOR OF MORE REHAB LTD
ACCREDITED EXPERT WITNESS

The White House Medico-Legal Services

Telephone:	0114 2630525	Fax:	0114 2630525
E-mail:	info@white-house-clinic.co.uk	Website:	www.white-house-clinic.co.uk

EDUCATION

Sheffield Hallam University September 2005 - 2012
Mrs of Science (MSc) – Advanced Physiotherapy

Sheffield Hallam University September 1998 - June 2001
BSc Physiotherapy 2:1

Final Dissertation: Students knowledge and experience of Informed Consent (and related Legalities)

King Ecgbert Secondary School September 1996 - July 1998

A-level	Biology, Chemistry and Geography
AS-level	Mathematics
GCSE	9 subjects at Grade C and above, including Mathematics, English and Dual Science

CURRENT POSTS

Managing Director of MORE REHAB - providing Multi-disciplinary Rehabilitation for Adults & Children with Neurological & Respiratory Conditions.

Private Out-patients at The White House Physiotherapy and Sports Injury Clinic, Consultant Physiotherapist

Partner of The White House Medico-Legal Services.

Worked in the Medical-Legal field for twelve years.
Area of Expertise:

- Individual Physiotherapy Reports for Adults and Children to include Hydrotherapy if required
- Multi-disciplinary Rehabilitation Cost Reports
- Professional Negligence Reports on Physiotherapy Issues
- Reports prepared for both Claimant and Defendant Cases
- Fully conversant with the implications of the Civil Justice reforms for Experts.
- Vetted member of the UK Register of Expert Witnesses.
- 1st Tier APIL Expert

SENIOR PHYSIOTHERAPIST POSTS

Senior Neuro-Physiotherapist at Sheffield Teaching Hospitals NHS Foundation Trust March 2008 – July 2008

Senior I Physiotherapist (Clinical Lead) in Neurological Rehabilitation at Sheffield Teaching Hospitals NHS Foundation Trust. March 2007 – March 2008

Senior Physiotherapist at Sheffield Teaching Hospitals NHS Foundation Trust covering the following areas (rotational): February 2003 – March 2007

Neurology Out-patients and Outreach Service
Specialised Medicine Rehabilitation
Community Rehabilitation Team
Neurosurgery and Medicine

JUNIOR PHYSIOTHERAPIST ROTATIONS

Rotations included August 2001 – February 2003

Neurology
Surgery (Respiratory and Amputee Rehabilitation)
Trauma
Medicine (Respiratory and Elderly Rehabilitation)
Elective Orthopaedics

Private Out-patients at The White House Physiotherapy and Sports Injuries Clinic June 2001 – August 2001

PUBLICATIONS/PRESENTATIONS AT CONFERENCE

Balaam, M., Rennick Egglestone, S., Hughes, A.M., Nind, T., **Wilkinson, A.,** Harris, E., Axelrod, L. and Fitzpatrick, G. **Rehabilitation centred design (2010).** In print. To be published in the adjunct proceedings of CHI.

Hughes, A. M., Burridge, J., Balaam, M., Harris, E., Rennick-Egglestone, S., Nind, T., **Wilkinson, A.** and Mawson, S. **(2010) Motivating Mobility - An exploration of developing upper limb rehabilitation technology tailored to individual stroke patients needs.** In: World Congress for Neurorehabilitation, 21-25 March 2010, Vienna, Austria. (Accepted)

Rennick Egglestone, S., Axelrod, L., Nind, T., **Wilkinson, A.,** Robertson, Z., Ricketts, I., Turk, R., Burridge, J., Mawson, S., Rodden, T., Smith, P. and Shublaq, N. **A framework for a home-based rehabilitation system**. **(2009).** Proceedings of Pervasive Health 2009, City University, London

Wilkinson A, Mawson S, Rennick Egglestone S, Hughes A, Nind T, Balaam M, Harris E, Burridge J **(2010) Using Motivational Theories to Inform Design of Assistive Technology for Motivating Rehabilitation**. In: World Congress for Neurorehabilitation, 21-25 March 2009, Vienna, Austria. (Accepted)

Wilkinson A J Motivating Mobility: Computer Games to Promote Physical Activity and Leisure for People who have had a Stroke. Yorkshire and North East Hub Poster Competition and Networking Event, Leeds April **2009.**

Wilkinson A, Mawson S, Rodden T **(2009) Motivation and Self-efficacy in Self-Management of Rehabilitation related to Technology Development.** PETRA 09 June 2009, Corfu, Greece

Vienna	June 2010 (4 days)
Pulmonary Hypertension Conference, Marlow, Buckinghamshire	November 2008 (2 days)
European Thoracic Society Conference, Berlin	October 2008
Spinal Injury Association – Solicitors Training presented regarding Hydrotherapy	November 2007
Filming a Patient Information DVD (Exercise) for PHA – now released	April 2007 (2 Days)
Patient Day Conference, Hilton, Sheffield	March 2007
Pulmonary Hypertension Conference, Dublin	November 2006
Pulmonary Hypertension Patient Day, Nottingham	October 2006
Pulmonary Hypertension Patient Day, Sheffield	April 2005

POST GRADUATE COURSES ATTENDED

MASCIP annual conference – managing complex needs (presented here)	October 2016
ACPIN annual conference	March 2016
APIL Annual Conference with Exhibition Stand	April 2015
Justifying new Technology in Rehabilitation, MLACP	November 2014
Effective Neuro-Rehabilitation	July 2014
APIL Annual Conference with Exhibition Stand	April 2013
EWI Annual Conference	October 2012
Completed Saebo Technician Course	March 2012
ACPIN Annual Conference	February 2012
Psychological Care of Clients with Neurological Injury	February 2012
Paediatric Association of Chartered Physiotherapists National Conference	October 2011
World Congress of Physical Therapy – to present research, attended neurological and paediatric streams	June 2011
APIL Annual Conference with Exhibition Stand	April 2001
Cortex Cognition Compensation Communication	January 2011
UK Stroke Forum	December 2010
Upper limb Functional Electrical Stimulation	October 2010
World Congress of Neuro-rehabilitation (presented poster)	March 2010
ACPIN National Conference – Upper Limb Recovery	March 2009
ACPIN Lecture Organised and Attended – 'Unsticking the Stuck'	February 2009
Motivational Interviewing in Brain Injury	November 2008
Contemporary Innovations in Neurological Rehabilitation – MSc module	October 2008– January 2009
Exploring clinical practice (neurological rehab)	Nov 2008 – December 2008
European Thoracic Society Conference	October 2008 – 4 days
Attended Bond Solon Expert Witness Training Courses	September 2008
Neuro-Rehabilitation Mrs Module	January 2008 – May 2008
Ethical and Legal Issues – MSc Module	Sept 2007 – January 2008
Spinal Injuries Association – Solicitor Training Day	November 2007
Hydrotherapy and Civil Litigation	October 2007
World Confederation of Physical Therapy, Vancouver (Neurology & Orthopaedic)	June 2007
OCPPP Conference - Paediatric Management	April 2007
Management of Neck Disorders - a Neurosurgical Approach	February 2007
Psychological Aspects of Brain Injury Rehabilitation	February 2007
Research Methods – MSc Module	Jan 2007 - May 2007
British Society of Rehabilitative Medicine Multidisciplinary Conference	December 2006
Bobath Course	Dec 2006 - Jan 2007 (6 days)
Clinical Outcomes – MSc Module	Jan 2006 - May 2006
Understanding Core Stability – MSc Module	Sept 2005 - Dec 2005
Report Writing	March 2006
Stroke Conference	April 2005
Fire Safety, Basic Life Support and Moving and Handling	Annual Updates
Sharing Good Practice	October 2004
Update on Stroke Development	September 2004
Management of High Tone	June 2003
On-call training	March 2003
ACPIN - Neural Control of Balance	February 2003
Respiratory Course	January 2003
McKenzie A - Back Course	November 2002 (3 days)
Introduction to Normal Movement	November 2002
Dealing with Violence and Aggression	August 2002
Health Care Records on Trial	June 2002
Human Rights Act Training	May 2002
Body Control Pilates - Level I and II	April 2002(2 days)

ADDITIONAL TRAINING SESSIONS ATTENDED

Constraint-induced Movement Therapy, Physiotherapy Management of the Upper Limb, Anterior Cervical Discectomy and Fusion, Spinal Surgery, Supratentorial Brain Tumours, Posterior Fossa Tumours, Music Therapy, Autonomic Nervous System, Hand Injuries, Rehabilitation of Head Injuries, Neurological Assessment, Neuromedicine on-call issues, Hydrotherapy, Joint replacements, Spinal Cord Injury, Spinal Injury Rehabilitation, Lumbar disc degeneration, Sling suspension, Paediatric management, Pool Rescue, Data Protection Act, Removal of implants, Infection control, Suction, Bagging, CPAP, Ventilators, Oxygen and Humidification, Amputee rehabilitation and transfers, Falls Rehabilitation, Exercise Physiology and many more.

TRAINING SESSION DELIVERED

Informed Consent
Legal Issues
Record Keeping and Legal Implications
Neurological Assessment and Treatment
Normal Movement
Neck and Spinal Surgery
Outcome Measures
Audit and Service Evaluation
Rehabilitation of Brain Injury – multiple sessions on various aspects
Stroke Rehabilitation – multiple sessions on different aspects

SERVICE DEVELOPMENTS, AUDIT AND RESEARCH

February 2007 – 2011

Obtained grant to explore Patients Perception, Expectations and Barriers to Exercise.

May 2005 - December 2006

Secondment to Research Obtained grant and created post for Physiotherapy lead in research Study looking at effectiveness of rehabilitation programme in patients with pulmonary hypertension. Presented at British Thoracic Society and at European Thoracic Society in October 2008.

2000/2001 - Research Project as Undergraduate

Project undertaken on Physiotherapy Student's knowledge and experience of Informed Consent.

PHYSIOTHERAPY PLACEMENTS (STUDENT)

White House Physiotherapy Clinic	June 2001 - Elective
Respiratory Care at Doncaster	March 2001
Orthopaedics at Doncaster	February 2001
Community at Sheffield	October 2000
Neuromedicine at The Royal Hallamshire Hospital, Sheffield	August 2000
Mental Health and Adults with Learning Disabilities at Barnsley	May 2000
Out-patient Rehabilitation at Barnsley	April 2000-
Burns and Plastics at Northern General, Sheffield	January 2000
Care of the Elderly at Derby	June 1999

OTHER WORK (INCLUDING VOLUNTARY)

White House Physiotherapy Clinic 1994 - 2001

Working as Physiotherapy Aide and Receptionist. Involved in running the Clinic at Weekends.

Riding for the Disabled. 1994 – 2000

Voluntary helper with mentally and physically disabled adults and children to enhance rider's experience, mobility and communication skills.

Cathedral Camps

Working on Lincoln Cathedral as part of team of Volunteers restoring the Cathedral.