

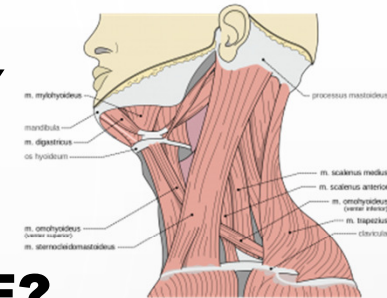
WHIPLASH REPORT: WHAT SHOULD IT CONTAIN?

MASS CONFERENCE 2017

Brian Simpson MCSP, DSA(CSP), MedCo Director

Brian Simpson MCSP, DSA(CSP)

MASS CONFERENCE 2017



BRIAN SIMPSON? WHO IS HE?

- 1) Extended scope Physiotherapist**
- 2) Clinician, lecturer and article author**
- 3) Medico-legal expert specialising in Clinical negligence**
- 4) Chairman of MLACP**
- 5) Director of MedCo and member of Expert Audit Cttee., Audit Cttee., Education and Training Cttee. and Medical Advisory Board**
- 6) Qualified 1967, NHS 1967-1970, Ipswich Town with Sir Bobby Robson 1970-1977, now humans only**

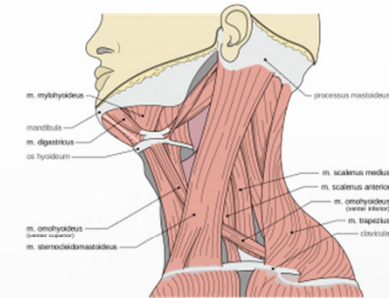
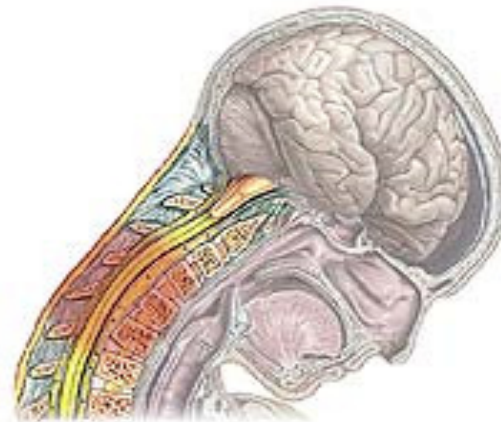
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Hyperextension



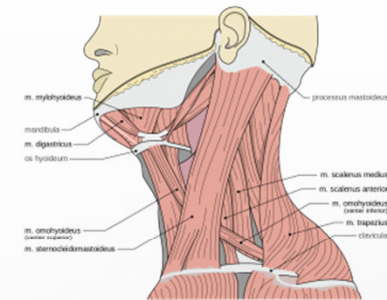
Sprain or strain of
cervical tissues

Hyperflexion



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 **ADAM.**

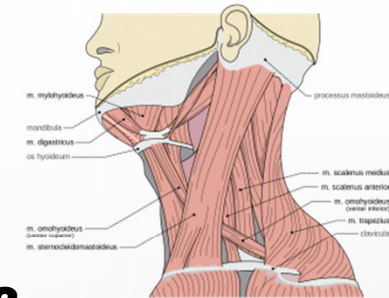


Relatively high speed whiplash trauma. Punches can be 25-43 mph.

Most RTA whiplash trauma at low speed.



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WHAT MAKES A GOOD REPORT?

MOJ RTA 3 FORM

Section A – Client details including photo ID

Section B – History of accident, immediate symptoms + T/t. If fully recovered –when

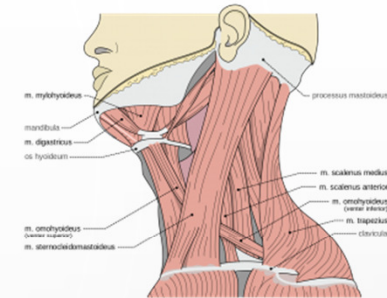
Section C – Effects of injury on employment, education + ADLs

Section D – Past medical history + examination. Diagnosis, prognosis, another report needed from another expert with another discipline e.g. psych?

Section F – Further T/t needed? Rehab?

Section G – Statement of truth. CPR Part 35.

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SECTION A – CLIENT DETAILS

**Has the expert confirmed that the person being examined is definitely the claimant?
i.e. photo ID**

Were medical records provided? If yes, which ones? *NB records not USUALLY required*

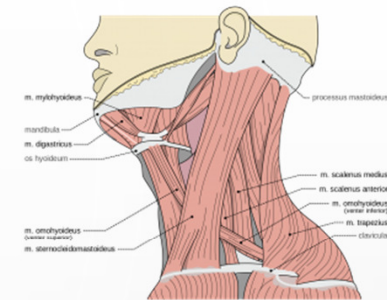
Age of claimant at time of accident?

Date of examination?

Date of report?

Instructing solicitor / MRO?

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SECTION B – HISTORY

Description of accident – vehicle damage? size of vehicles? direction of impact? speed of impact?

Head restraint?

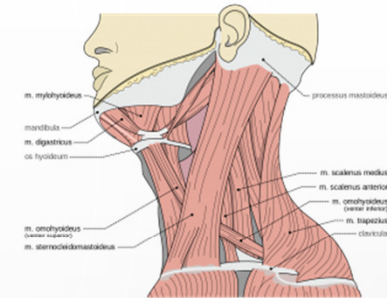
Seat belt? If not, did the client have exemption? Was client treated as in-patient? Out-patient? Privately?

Were symptoms immediate or delayed onset?

Any previous similar problems?

On-going symptoms? Position reported by claimant?

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SECTION C – EMPLOYMENT POSITION / EDUCATION

Details of claimant's employment/ education at time of accident

Any absences, part-time work, light duties prior to accident?

Claimant's current work / educational situation?

Any practical difficulties, symptoms, restrictions?

Impact of injury on hobbies, recreation, housework, gardening, sex life, etc.

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SECTION D – PAST MEDICAL HISTORY

Pre-existing OA at time of accident?

Previous WAD?

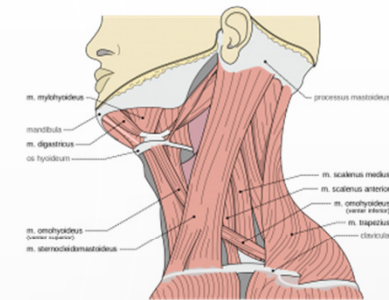
Medical records needed? Usually not but they are sometimes a great help

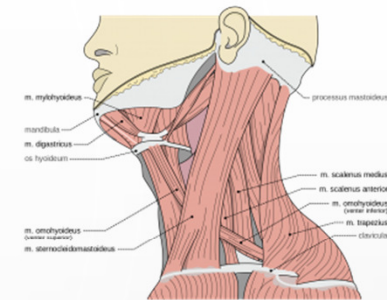
Findings on examination

Diagnosis, opinion and prognosis

Will claimant make a full recovery Recent study 90% are fully recovered in < 12 months and 60% in < 6 months MedCo has an average prognosis chart and experts regularly recommending a prognosis period outside the norm will be checked

Any further T/t needed? More time for final prognosis? Psych assessment? Follow-up report needed?



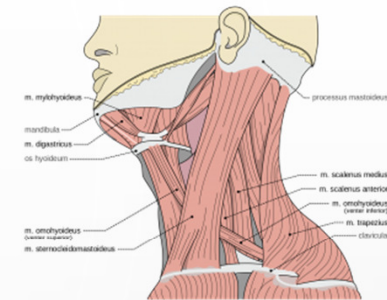


SECTION E – SEATBELTS

Was claimant wearing seatbelt?

If not, any exemption? Would injuries have been different if seatbelt had been worn? *NB Seat belts are shown to ▲ severity of WADs but they ▼ death rates. However, this fact is not an excuse to not wear a seatbelt.*

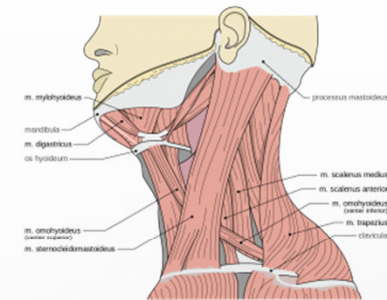
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Section F – Future T/t and Rehabilitation

Does the client require any treatment / rehabilitation in the future in order to return to full function?

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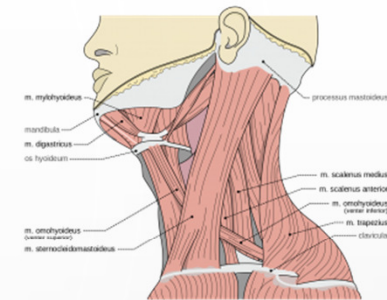


SECTION G – STATEMENT OF TRUTH

Civil Procedure rules Part 35.3 “ It is the duty of experts to help the court on matters within their expertise. This duty overrides any obligation from whom experts have received instructions or by whom they are paid”

NB the random selection of experts via the MedCo portal is intended to help prevent the “cronyism” which seemed to be rife at one time whereby an expert would give an extended prognosis opinion to certain solicitors.

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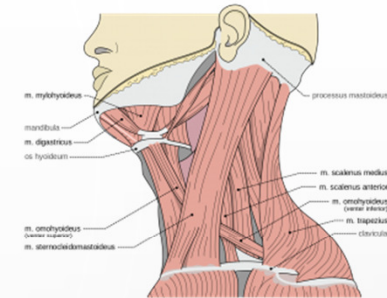
WHAT MAKES A GOOD REPORT?

1) A GOOD EXPERT – all experts doing MedCo reports will have completed the MedCo-accredited training programme and should all know the answer to this question.

Most experts are honest and thorough but the MedCo Board and committees are only too aware of the number of cases of below-standard reports and clear below-standard examinations taking 5 minutes or less.

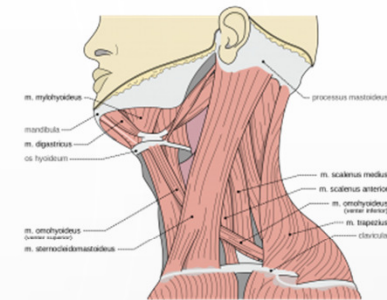
Check expert's CV - Some experts are claiming qualifications to which they are not entitled. If they are doing so, report is invalid.

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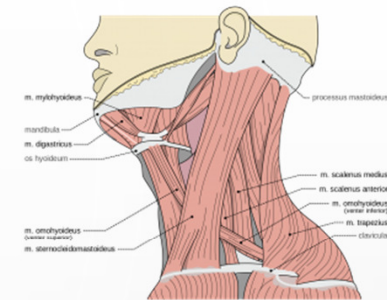
- **THE AGE AND GENDER OF THE DRIVER;**
- **THE EXACT LOCATION AND TYPE OF IMPACT;**
- **THE RELATIVE SEATING POSITION OF THE DRIVER;**
- **THE SIZE, SHAPE AND STIFFNESS OF THE VEHICLES INVOLVED;**
- **THE PRESENCE OF AIRBAGS AND OTHER RESTRAINT SYSTEMS; AND**
- **THE AMOUNT OF TIME BEFORE MEDICAL ATTENTION SOUGHT**

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2) GOOD HISTORY

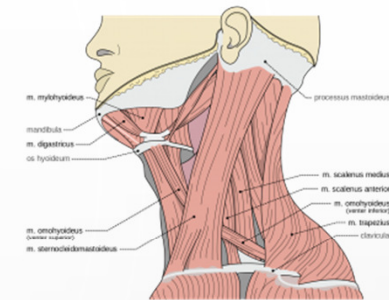
- A) **Relevant clinical history – probably full notes not required. Any pre-existing OA? E.g. 75yo –v- 25yo. Completely different level of pain, tissue damage and prognosis**
- B) **Accident details -**
- C) **Patient details – age, etc.**



2) GOOD HISTORY

B) Accident details – Vehicle damage? Size of vehicles (lorry -v- car). Direction of impact? Speed of impact?

- Head restraint? Seat belt? Orientation of head? NB. Head restraints = ▲ WAD damage but ▼ deaths.



GOOD EXAMINATION

Check ROM – Passive, Active and Resisted

Observe posture, gait, bruising, facial expression

Check reflexes, tenderness in neck, shoulders, between shoulder blades (facet joints, scalenes, sterno-mastoid, trapezius and levator scapulae), thoracic spine and sometimes lumbar spine

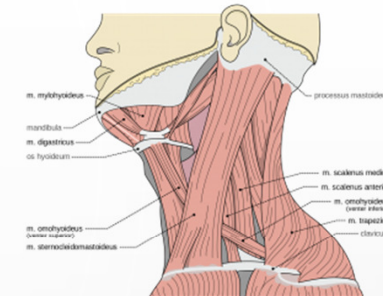
Check for altered sensation – paraesthesia

Check for muscle symmetry, bruising, abrasions, scars etc.

Client should be stripped to the waist (bra should not be removed) to enable the expert to:-

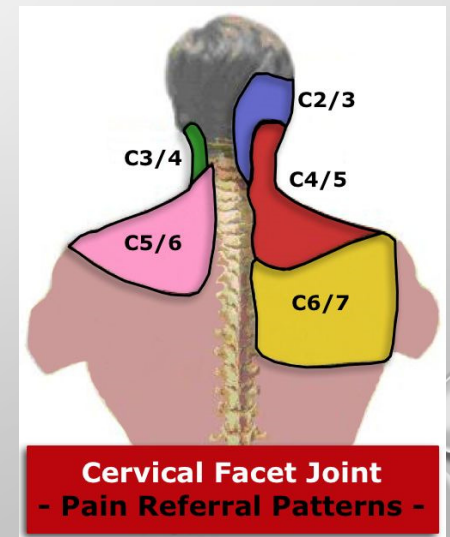
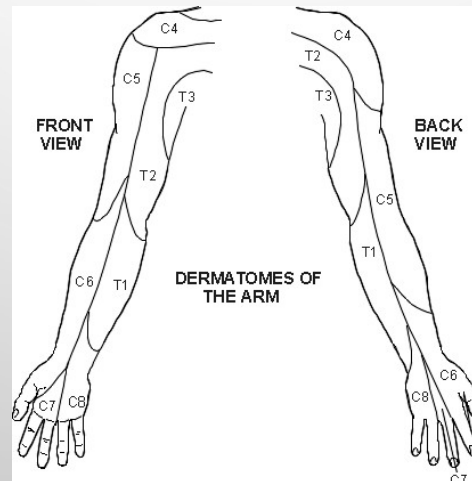
LOOK, FEEL and MOVE

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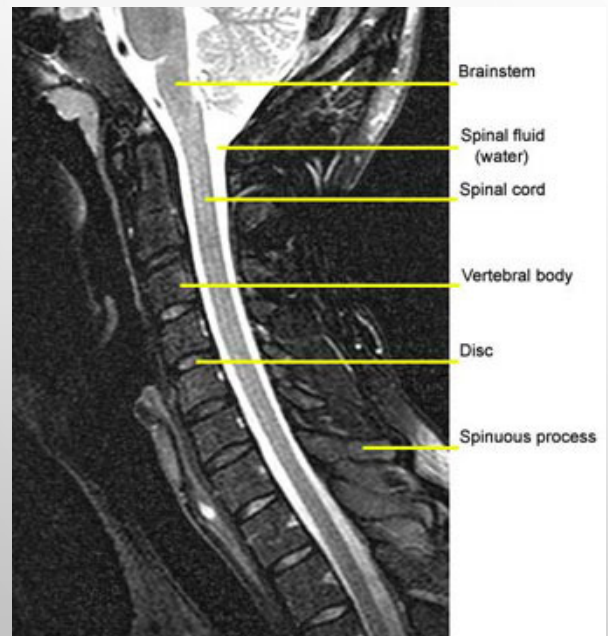
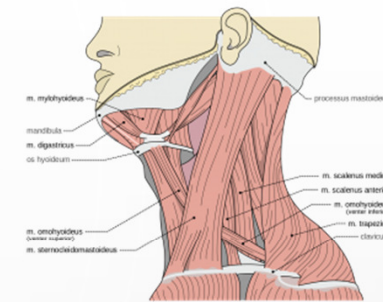


GOOD EXAMINATION Cont'd

NB – pain in neck, thoracic spine and shoulders is often ALL from a neck injury and not necessarily from separate injuries. This pain is referred in a different way to that of nerve compression pain referral.



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It is rare that X-ray or MRI is required in most WAD cases but they may be requested in more severe cases when bony or neurological injury may be suspected.

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THANK YOU

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