Mr Andrew D Carrothers
VR, MBChB, MA (Cantab), DipIMC RCSEd, FRCS (Tr & Orth)
Consultant Orthopaedic Surgeon
Assistant Professor, University of Cambridge

Specialist Interest in Pelvic & Acetabular Trauma, complex lower limb injuries and multiply injured patients, primary and revision hip and knee replacement surgeries

Consultant **Trauma** & Orthopaedic Surgeon

MEDICAL REPORT PREPARED FOR THE COURT
by
MR ANDREW D CARROTHERS
CONSULTANT TRAUMA & ORTHOPAEDIC SURGEON
ASSISTANT PROFESSOR, UNIVERSITY OF CAMBRIDGE
On
John Hartland

Date of Birth:	7 July 1964
Address:	3 North Star Court, King's Lynn, Norfolk PE30 2NF
Occupation:	Full time psychotherapist
Date of Index Event:	7 September 2022
Time off work:	Approximately 6 weeks
Prepared for the Court by:	Mr Andrew D Carrothers Consultant Trauma & Orthopaedic Surgeon
Instructed by:	Slater + Gordon Lawyers
Reference:	HAR63825/GSD
Date of Instruction:	29 March 2023
Place of Examination:	Nuffield Hospital, Cambridge
Date of Examination:	13 April 2023
Date of Report:	13 April 2023

Please note: This report should be viewed in colour. All video appendixes should be available for viewing along with this report.

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Consulting Rooms:
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GMC No: 6028553

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www.carrothersorthopaedics.co.uk

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- **Appendix i. Abbreviated CV.**
- **Appendix ii. Patient Questionnaires.**
- **Attachments. Video file 1 and 2.**

ABOUT THE AUTHOR:

I am a Consultant Orthopaedic Trauma surgeon at Addenbrooke's Hospital in Cambridge. Addenbrooke's is the Major Trauma centre for East Anglia, and hence deals with the majority of the region's complex trauma. I am currently the CUH Addenbrookes Trauma & Orthopaedic Clinical Governance Lead, having been CUH Addenbrookes Trauma Research Lead since 2019.

I am one of six orthopaedic specialist trauma surgeons with a personal subspecialist interest in pelvic complex trauma, and I regularly treat patients who have sustained multiple injuries.

I take part in the consultant on call rota for trauma and have a weekly fracture clinic for patients sustaining all types of orthopaedic injuries.

My areas of specialist interest are pelvic and acetabular (hip joint) fractures, open fractures, multiply injured patients and complex lower limb injuries. In addition I am a specialist hip and knee replacement surgeon undertaking in the region of 200 hip and knee replacement primary and revision surgeries each year.

As 1 of the 4 regional pelvic and acetabular surgeons we receive referrals from throughout the East of England (population 5.5million) for advice and definitive management of pelvic and acetabular fractures and complex trauma through our web referral form www.cambridgepelvicsurgery.co.uk

I have a significant academic interest in pelvic and acetabular fractures and as UK Chief Investigator of the NIHR NHS AceFIT Feasibility trial I have a £350,000 grant awarded. This is a randomised trial comparing non-operative management, vs fixation, vs fix and replace for older patients who have sustained acetabular fractures.I have been the principal investigator in Cambridge for National trauma trials including: AIM – A prospective trial into the management of ankle fractures in older patients & FiXDT – A prospective randomised trial into the management of distal tibial fractures.

SUMMARY OF INSTRUCTIONS

I have been instructed by **Gurj Sidhu, litigation executive, Slater & Gordon Lawyers** to provide a medical report on the injuries sustained, any treatment given and to give an opinion on prognosis concerning an accident that happened to the Claimant on the 7th September 2022.

Prior to seeing the claimant, I had a negative COVID test.

Throughout, I wore appropriate PPE as per the standards within the NHS.

His identity was confirmed with a UK passport and UK driving license.

SUMMARY

1. Mr Hartland is a 58-year-old gentleman who was 58 years of age at the time of the index accident, 7 months ago, on 7th September 2022. At that time, he sustained a reverse oblique subtrochanteric fracture of the right proximal femur and underwent open reduction internal fixation with intermedullary nail DePuy synthes TFNA femoral nail on 08/09/2022. At 7 months post-accident and surgery, he has got significant ongoing issues with his right hip and right lower limb in terms of shortening, pain, stiffness and loss of function. His review with current symptom profile and examination suggests degenerative change within the right hip. He denies having had any problems with his right hip prior to this injury. I have recommended an MRI scan with metal artefact reduction sequence to his right hip and he will have an addendum report when a musculoskeletal radiologist report has been provided as well as the MRI images.
2. He continues to utilise a single stick or crutch whilst outdoors with pain and stiffness, after only 50 metres of ambulation. He reports he is due to be reviewed by his orthopaedic team in King's Lynn Hospital one-year post-accident. He was discharged from physiotherapy and discharged from hospital, and reports having had no outpatient physiotherapy formal rehabilitation.
3. I would recommend that he has an urgent orthotist review to consider appropriate orthotics, to minimise the risk of deterioration in his other large weight bearing joints such as his left knee and lower spine. In addition, I recommend he has ongoing physiotherapy for up to 3 months, once weekly, to help him plateau his recovery. I recommend he has a formal medicolegal report from psychologist/psychiatrist to which I defer to.
4. I would want to review this gentleman for his final medicolegal report approximately 12 months after his injury when on the balance of probability, he will have plateaued his recovery. He will need to have further x-rays of his right hip at that time.

5. On the balance of probability, with his current deteriorating issues within his right hip, pending recommended MRI scan review, it is likely that he will need to consider removal of metalwork and potential total hip replacement surgery within perhaps 1-3 years as a direct result of his index accident and injury sustained.

HISTORY

6. Mr Hartland, a 58-year-old gentleman, had no problems with his right hip or lower limb prior to this index accident and injuries sustained. This was corroborated by the medical notes provided.

THE ACCIDENT

Events and Mechanism of injury:

7. At approximately 09:45 hours on 07/09/2022 Mr Hartland was cycling his pushbike along King Street, as he approached the customs house, the defendant opened his driver side door across his path. As a result, during the course of attempting to take evasive action, Mr Hartland made impact with the door and fell to the ground.

INJURIES SUSTAINED

(i.) Closed right sided reverse oblique subtrochanteric right proximal femoral fracture necessitating an intramedullary hip screw right side surgery on 08/09/2022.

(ii.) Soft tissue injury right foot.

(iii.) Psychological injury.

TREATMENT

Immediate treatment:

8. Mr Hartland was taken from the scene of the accident by ambulance to Queen Elizabeth Hospital emergency department where he was admitted under orthopaedics for a total of 13 nights.

9. His ambulance documentation describes the mechanism of injury and pain that was not relieved with intravenous morphine and paracetamol. Ketamine was also administered which allowed patient extrication and transfer to Queen Elizabeth Hospital.

SUPPLEMENTARY COMMENTS

This patient was riding his bicycle along a main road and swerved to avoid a car door that had recently opened. Patient fell to the floor and thought he felt a clip in his right leg. On arrival the patient was alert and orientated and there was no loss of consciousness throughout there was also no amnesia. The primary survey was as follows: The airway was clear and self maintained The chest was clear and equal air entry with no subcutaneous emphysema chest was intact The respiratory rate was normal The patient did not look shocked they were good colour there was no pelvic injury there was extreme pain around the right femur so there was a suspected right femur. The abdomen was soft and non-tender The patient's Glasgow coma score was 15 out of 15 he was orientated to time personal place I was able to move all four limbs although the right leg was very painful to move around the thigh. There was no abnormal physiology seen when the monitoring was attached physiology remained constant throughout. There were however episodes of breath holding when initial doses of ketamine were given with some drops and saturations which was dealt with by asking the patient to take deep breaths while providing high flow oxygen concentration through a NRM. The ambulance crew had given 20 mg of morphine and a gram of IV paracetamol but the patient was still complaining of extreme pain whenever they tried to straighten the right leg. Therefore the patient was given ketamine initially 30 mg followed by 20 followed by another 20 mg giving a total of 70 mg of ketamine. Ketamine sedation was uneventful prior to ketamine sedation a BPM was assembled with a suction and a pre-sedation checklist was carried out. Patient was subsequently extricated with a KTD to the right leg placed on an orthopaedic scoop and extricated onto an ambulance trolley. The patient was taken to the Queen Elizabeth Hospital accident emergency department as the patient was MT negative. A pre-alert was given prior to leaving seen in the DSA following the ATMISTER. Handover was unremarkable and was given to a doctor lead A&E team. The rest of this patient record was completed by the ambulance crew. These notes were completed by Chris Neil Advanced Paramedic.

IMPRESSIONS

Assessment Time	Item	Details
07/09/2022 12:58:59	**Limb Injury**	**Details**: Suspected mid shaft R femur #

CARE PLAN

REFERRALS

Item	Details

REFERENCES

PATIENT OUTCOME

General	**Patient Outcome:** Treated and Transported

INCIDENT - Tawn, Lisa

	Time	Details	Complications / Misc
Incident Date / Time	07/09/2022 09:40:24	**Address 1:** O/s Flat 5 3,King Street **City / Town:** King's Lynn; **Postal Code:** PE30 1ET **Tel1:** [redacted]	

10. Discharge letter shows date of admission 07/09/2022. Discharge date 20/09/2022. Discharging consultant Mr Jeffrey, consultant orthopaedic surgeon. Discharged 50% weight bearing for 3 months and fracture clinic with Mr Jeffrey, discharge medication Enoxaparin, fresubin, paracetamol, laxatives, morphine sulphate and dihydrocodeine.

Case Notes Copy

JOHN ROBERT HARTLAND **NHS number:** **4844704710** **Hospital Number:** **D664662**

NHS

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Patient Discharge Summary

Email sent to op Enq for opA. 8/9/22

Inpatient Letter

JAJ 27/9/22 @ 15:30

Patient demographics

Patient name	JOHN ROBERT HARTLAND	**Patient sex**	Male
Patient address	3 NORTH STAR COURT	**Date of birth**	07/07/1964
	KING'S LYNN	**Patient marital status**	Married
	NORFOLK	**NHS number**	484 470 4710
		Other identifier	D664662
	PE30 2NF	**Patient telephone number**	01553 763778 (Home)

Admission details

Date of admission	07/09/2022 20:30
Source of admission	Usual place of residence
Admission method	Emergency - A+E Dept.

Discharge method
Discharged on clinical advice/consent

Discharge destination - Usual place of residence

Diagnoses
Primary Diagnosis: Right NOF#
Relevant previous diagnoses: Liver cirrhosis, previous shoulder surgery

Reason for admission
Sustained a fall after being knocked off bike by an open car door

Clinical summary (Include Comorbidities, VTE and AKI)
Admitted following a collision with a bike. Sustained a right neck of femur fracture. Had an intramedullary nail. Post operatively recovered well although had significant pain, may benefit from a prolonged wean for pain relief.

50% weight bearing for 3 months. For follow up with Mr Jeffery. A fit note has been written.

Comorbidity: Previous substance misuse and cirrhotic liver disease
Comorbidity: Previous humoral fracture

Allergies and adverse reactions - See EPMA section

Safety alerts (e.g. BBV, MRSA, Falls, Anticoagulation)
Increased bleeding risk whilst on clexane with cirrhotic liver disease

Legal information (e.g. DNR status, Mental capacity status, Safeguarding)
Consent for treatment given
ReSPECT form completed – CPR recommended
A fit note to the 4th January 2023 has been written by Mr Jeffery

Plan and requested actions (e.g. Hospital, GP, Community or Health Visitor)
partial weight bearing with crutches for next 3 months.
Actions for hospital: follow up w JAJ's clinic on 27/9

[481434/3]

JOHN ROBERT HARTLAND **NHS number: 4844704710** **Hospital Number: D66466**

Medications and medical devices
Medication started: Enoxaparin 40mg subcutaneous injection BD
Short-term analgesia and laxatives

Person completing record (Please enter name, bleep, contact number)
Name: Omolara Stevens
Role/Grade: F1
Bleep/contact number: 4220

EPMA
TTO - Discharge Medication

TTO Drug	Dose	Frequency	Route	Duration	GP To Continue	Verified By
ENOXAPARIN (Prefilled Syringe) 40mg in 0.4ml Injection	40 mg	TWICE a day (morning, evening)	Subcutaneous Injection	16 days	No	GLADMAN,THOMAS
FRESUBIN (Vanilla) 3.2cal Feed	125 mL	TWICE a day (morning, midday)	Oral	7 days	Yes	GLADMAN,THOMAS
[either/or protocol 2] PARACETAMOL 500 mg Tablets	1000 mg	FOUR times a day	Oral	7 days	No	GLADMAN,THOMAS
MACROGOL COMPOUND Oral Powder Sachets	1 sachet	ONCE a day (midday)	Oral	7 days	No	GLADMAN,THOMAS
[either/or protocol 1] MORPHINE SULPHATE 10 mg in 5mL Oral Solution	10 mg	Every 2 hours PRN Pain	Oral	7 days	No	GLADMAN,THOMAS
LACTULOSE Oral Solution	15 mL	TWICE a day (morning, evening)	Oral	7 days	No	GLADMAN,THOMAS
DIHYDROCODEINE 30 mg Tablets	30 mg	FOUR times a day	Oral	7 days	No	GLADMAN,THOMAS

Allergy Status

Allergies	Reaction
***No Known Drug Allergies	

GP practice

GP name	Dr MICHELLE NOWERS (D82044)
GP practice details	D82044 VIDA HEALTHCARE King's Lynn Norfolk
GP practice identifier	D82044

Discharge details

Discharging consultant	Mr J Jeffery
Discharging specialty/department	Trauma & Orthopaedics
Ward	Gayton Ward
Date of discharge	20/09/2022 19:00

[481434

11. Whilst in the emergency department his diagnosis was made, he had a fascia iliaca block and was subsequently admitted under the orthopaedic team. He was noted to live in a house with his bed and bathroom upstairs and to be married with one child. Ex smoker 20 years previously smoked 30 a day. His previous history of IVDU hep C and cirrhotic liver was noted. Discussed in the trauma meeting and planned for an intermedullary nail device right side.
12. Urinary catheter inserted.
13. On the following day, 08/09/2022, he was taken to theatre under the care of consultant Mr Jeffrey and surgeon Mr Sheikh for right sided intermedullary femoral nailing. Traction table utilised, reamed to 14mm and a TFNA DePuy Synthes 12mm x 440mm 130-degree angle femoral nail inserted. Use of 120mm TFNA screw and 2 distal locking screws 5mm each 60 and 52mm.
14. Post-operatively he was planned to be mobilised partial weight bearing on crutches and follow up with Mr Jeffrey in 2 weeks' time, VTE prophylaxis.

The Queen Elizabeth Hospitals Kings Lynn

Operation Surgeon Report

Confidential Printed : 08/09/2022 5:23 pm

Surname: HARTLAND	Title: MR	Casenote: D664662
First Name: JOHN ROBERT		NHS Number: 484 470 4710
Address: 3 NORTH STAR COURT, KING'S LYNN		D.O.B: 07-July-1964
Postcode: PE30 2NF	Gender: Male	Age
Phone (Home): 01553 763778		Pre-Op ward: Gayton Ward

Consultant	Surgeon(s)	Anaesthetist(s)	Date Of Operation
James Jeffery			08 Sep 2022

Proposed Procedure RIGHT FEMUR IM NAILING

Planned Procedure Code(s) W28.1

Actual Procedure RIGHT FEMUR IM NAILING

Actual Procedure Code(s) W28.1

Post-Op Instructions

MOBILIZE partial weight bearing ON CRUTCHES.

IV ANTIBIOTICS 2 DOSES.
CLEXANE for next 3 days.
Analgesia as required.
CHECK BLOODS.
KEEP WELL HYDRATED.
f-UP WITH mR jEFFERY IN 2/52.

Signature of Medical Officer: _____ **Date:** 08/09/22

Print Name: R SHEIKH

*** End of Report ***

The Queen Elizabeth Hospitals Kings Lynn

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Operation

INTRAMEDULLARY NAILING Right FEMUR. R Sheikh/Litty

Incision details

LATERAL INCISIONS PROXIMAL AND DISTAL FEMUR

Findings

DISPLACED COMMINUTED SUBTROCHANTERIC FRACTURE Right femur

Procedure

INTRAMEDULLARY NAILING Right FEMUR DEPUYSYNTHES TFNA NAIL
II CONTROL.

TRACTION TABLE. FRACTURE ALIGNED TO BEST POSITION.
BETADINE SCRUB.

ENTRY PORTAL MADE ON TOP OF GREATER TROCHANTER AND MEDULLARY CANAL ENTERED WITH GUIDE WIRE.

ENTRY PORTAL ENLARGED WITH PROXIMAL REAMING DRILL.

BULL NOSE GUIDE WIRE INSERTED AND FEMUR REAMED.

CHATTER PRODUCED AT 14mm REAMING. REAMED TO 14mm TO ALLOW INSERTION OF 12mm 440mm LENGTH NAIL (Longest nail available). NAIL INSERTED ACROSS FRACTURE SITE INTO DISTAL FEMUR.

PROXIMALLY GUIDE WIRE AND DRILL USED TO CREATE HOLE FOR LAG SCREW . 120 MM LAG SCREW DISTAL LOCK x 2. HAEMOSTASIS.

CLOSURE VICRYL. vicryl rapide to skin .

AQUACEL DRESSING

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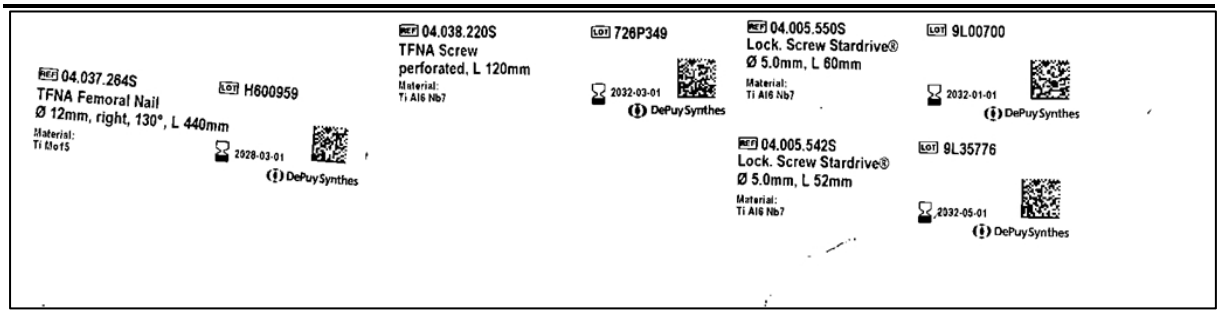

The Queen Elizabeth Hospitals Kings Lynn

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Gender	Male
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Casenote	D664662
NHS Number	484 470 4710
D.O.B	07-July-1964
Age	
Pre-Op ward	Gayton Ward

Consultant	Surgeon(s)	Anaesthetist(s)	Date Of Operation
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Post-Op Instructions

MOBILIZE partial weight bearing ON CRUTCHES.

IV ANTIBIOTICS 2 DOSES.
CLEXANE for next 3 days.
Analgesia as required.
CHECK BLOODS.
KEEP WELL HYDRATED.
f-UP WITH mR jEFFERY IN 2/52.

Signature of Medical Officer: _____ **Date:** 08/09/22

Print Name: R SHEIKH

***** End of Report *****

The Queen Elizabeth Hospitals Kings Lynn

Operation Surgeon Report

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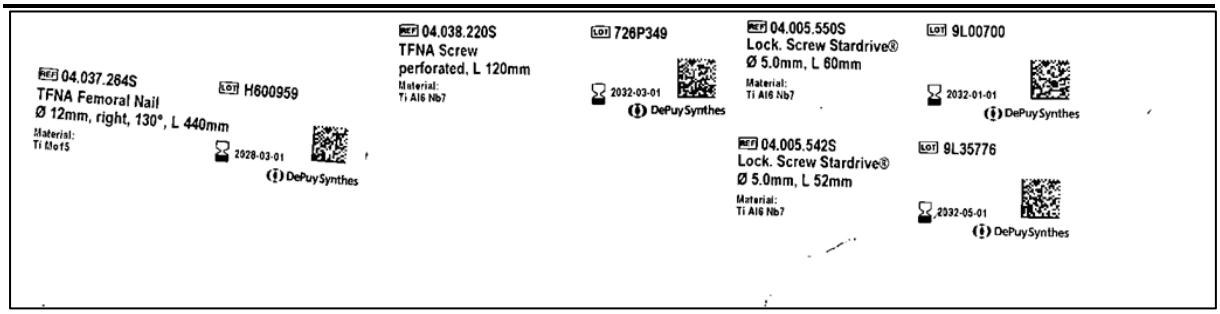


15. He was managed post-operatively on the ward with physiotherapy, orthopaedics and nursing care until his date of discharge.

ORTHOPAEDIC DEPARTMENT

MR. J. JEFFERY

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

SURNAME	HOSPITAL REG No. K_664_662		TELEPHONE No.
FIRST N	HARTLAND, JOHN ROBERT 3 NORTH STAR COURT KING'S LYNN	OF BIRTH	TEMPORARY ADDRESS
ADDRE	NORFOLK , PE30 2NF M NO M	07/07/1964	
	DR M NOWERS 484 470 4710		OCCUPATION
G.P.		RELIGION M M S F W	DISEASE INDEX NUMBER

Date and Initials
07.09.22
JAJ/KB

K 664662 – John Robert HARTLAND

Mr Hartland is a 58 year old man, admitted as an emergency with a reverse oblique subtrochanteric fracture of his right proximal femur.

Mechanism of injury: riding his bicycle, apparently knocked off by a car door which opened in front of him.
Date of injury: 7th September 2022.
Operation: intramedullary nail stabilisation right femoral fracture (8th September 2022).
Surgeon: Mr Sheikh. Assistant: Litty Kambolath. Anaesthetist: Dr. Ben Fox.

Closed reduction of fracture on traction table. Femoral canal reamed to 14mm with flexible reamer.

440mm/12mm right, 130° Depuy Synthes TFNA femoral nail inserted.

120mm proximal screw.

Two distal locking screws inserted (52mm and 60mm).

Full reduction achieved.

Image intensifier films saved to PACS.

Closure – Vicryl in layers, Vicryl Rapide to skin.

Post-operative instructions – 50% partial weight bearing, restriction with two crutches for the next 3 months.

Mr Hartland has a history of liver cirrhosis possibly secondary to previous intravenous drug abuse.

He is an ex-smoker (stopped 20 years ago, previously smoked 30 a day).

He lives in a house, he is married with one child. He works as a Psychotherapist (off-work certificate has been given until 4th January 2023).

He is of large build, stated weight from patient approximately 20 stone.

Cont....

MRO367

607

HARTLAND, JOHN ROBERT
3 NORTH STAR COURT
KING'S LYNN
NORFOLK
, PE30 2NF
M NO M 07/07/1964
DR M NOWERS
484 470 4710

07.09.22 JAJ/KB	**K 664662 – John Robert HARTLAND**	Chaperone: HCA T Goble
	Cont.....	
	Post-operatively he had fairly significant discomfort and was quite slow to mobilise.	
	He was discharged home on 20th September, able to climb and descend stairs at that stage.	
	Follow-up appointment arranged for 27th September.	
27.09.22 JAJ/KB	**K 664662 – John Robert HARTLAND**	Chaperone: HCA T Goble
	Patient DNA'd today's appointment.	
	He did not call or make contact to say that he was not coming.	
	We will arrange a further appointment, it may well be that at this stage he is not sufficiently mobile to easily attend a Hospital Clinic appointment.	
	Letter written to patient to clarify the above.	
	Letter to G.P.	

Medical consultations as outpatient

16. DNA Mr Jeffrey's fracture clinic 27/09/2022. Further appointment given.

17. No consultations provided either in the general practitioner or King's Lynn Hospital notes. Mr Hartland reports having had a fracture clinic appointment approximately 3 months post-surgery under the care of Mr Jeffrey and none since. He was due to have a 12-month appointment but has not got a date.

18. Bone DEXA scan 29/11/2022 T-score of -1.1 is considered moderately low. Z-score of -0.5. This patients bone mineral density is within normal limits for their age and sex even though bone loss may have occurred.

Bone Dens Nov

The Queen Elizabeth Hospital

Gayton Road
King's Lynn, PE30 4ET
Phone: 01553 613613

Bone Densitometry Report: 29 November 2022

Referring Physician: P SARDA

PATIENT:

Name:	HARTLAND, JOHN ROBERT				
Patient ID:	D664662	**Birth Date:**	07/07/1964	**Height:**	190.5 cm
Sex	Male	**Measured:**	29/11/2022	**Weight:**	124.3 kg
Indications:	Family Hist. (Parent hip fracture), Family History of Fracture, Family History of Osteoporosis, History of Fracture (Adult), Liver Disease	**Fractures:**	Hip	**Treatments:**	Calcichew

ASSESSMENT:

The BMD measured at Femur Total is 0.947 g/cm² with a T-score of -1.1 is considered moderately low.

With a Z-score of -0.5, this patient's BMD is within normal limits for their age and sex, even though bone loss may have occurred.

World Health Organization (WHO) criteria for post-menopausal, Caucasian Women:
Normal: T-score at or above -1 SD
Osteopenia: T-score between -1 and -2.5 SD
Osteoporosis: T-score at or below -2.5 SD

Please note: This report is generated by the scanner software based on the measurements obtained during examination.

FRAX® (10 Year Probability of Fracture):

Major Osteoporotic Fracture: 12.0 %
Hip Fracture: 0.6 %
Population: UK
Risk Factors: Family Hist. (Parent hip fracture), History of Fracture (Adult)

RECOMMENDATION:

We do not provide clinical advice on treatment, but should you require further information, please refer to the following national bodies:

- Fracture Risk Assessment (FRAX®) Guidelines: www.shef.ac.uk/FRAX
- National Institute for Health and Clinical Excellence (NICE) Guidelines: www.nice.org.uk
- National Osteoporosis Guideline Group (NOGG) Guidelines: www.shef.ac.uk/NOGG

FOLLOW-UP:

Follow-up scans may be performed to monitor response to osteoporosis treatment or to monitor changes in BMD in individuals not receiving treatment; however, since it is unlikely that a significant change in BMD will be detectable in less than two years, BMD measurements are not repeated more frequently than this. In all cases, a follow-up scan should only be considered where this may influence patient management or new risk factors have developed.

Relevant GP appointments

19. None.

Physiotherapy Treatment

20. Mr Hartland had daily physiotherapy throughout his inpatient hospital stay but did not have any physiotherapy thereafter for his rehabilitation.

Current Symptoms

21. At 7 months post index accident and injuries sustained with necessary surgery, Mr Hartland remains rather stoical but actually has significant limitations in his gait, activities and quality of life. He describes a 6-week period of acute phase of recovery when his right foot, which was swollen and bruised, completely settled and he has not had any problems with this since. He describes his ongoing recovery phase for 6 months and currently ongoing, he feels that he has not plateaued his recovery.

22. He describes episodes of dull discomfort type pain particularly in his deep buttock and lateral aspect of his right hip. He is less aware of anterior groin pain but can have these episodes when he twists. He has accepted a significant limp and tends to utilise a stick or his crutch if he is out of doors and particularly over 50 metres when he tires quickly and has increasing right hip pain. He describes a separate pain profile which he has been aware of since the time of his injury which he describes as an itching type discomfort in the anterior and lateral aspect of the right thigh which can keep him awake in bed at night. It is particularly troublesome when he lies recumbent. He prefers to sleep on his side with a pillow between his knees, which is a new adaptation for him. He can sleep on his left side but not the right. He has difficulty sleeping on his back. He describes having previous orthotics for his pes planus (flat feet) which he no longer uses. His right hip pain has eased by sitting or at rest. He denies any significant or new lower back pain or knee discomfort.

23. He reports that 3 months post-surgery he weened himself off all his analgesics as he prefers to understand his body's pain profile.

24. He only got back to driving his manual car 2-3 weeks ago and is aware of his 1-hour journey whereby he has driven from King's Lynn for his appointment in Cambridge, he has to shift his position within his driving seat. He tends to now share his driving more with his wife.

25. He has two flights of stairs at home which he is utilising for exercise and trying to strengthen and rehabilitate, his hip can be more uncomfortable particularly going downstairs when he is heavily reliant on the banister both going up and down.

26. He is acutely aware of his change in being able to play his 7-year-old daughter, who now has to sit on his left leg and not the right. He is unable to get on the floor and be comfortable whilst playing with her.

27. He describes his accident and ongoing issues having an adverse effect in his sexual relations. He has to use different positions and overall has decreased frequency and quality of sex. He has got no deficit in terms of erection or ejaculation.

Psychological Symptoms

28. This is not my area of expertise. I am not able to comment on causation or prognosis for psychological trauma. Having said that, Mr Hartland reports ongoing issues with tearfulness, anxiety and depression since the time of his accident. He is aware that he is increasingly irritable due to his ongoing symptoms and pain profiles. In this regard I would recommend formal medicolegal report from a psychologist/psychiatrist to which I defer to.

Patient Reported Outcome Measures – completed on 18/03/2023

29. Symptoms are more formally described in the attached (**Appendix ii**)

30. The EQ-5D is a validated quality of life scoring system used in patients following trauma. His EQ-5D score prior to the accident was 1 (answers 11111), self-reported score 95%. His EQ-5D score today is 0.536 (answers 42322), self-reported score 80%

31. The DRI is a validated scoring system used for patients following lower limb injuries. Self-reported some difficulty with dressing, out of door walks and climbing stairs. Some difficulty standing, bent over a sink, carrying a bag and making a bed. Not able to run. Difficult with light work. Not able for heavy work or lifting heavy objects. Great difficulty in participating in exercise.

32. The Oxford Hip Score is a validated scoring system mainly used in patients with hip arthritis but also following hip replacements. That said it is still useful to objectively document patients' symptoms following hip injuries. Right side 31 (score 30-39 may indicate mild to moderate hip arthritis).

PREVIOUS MEDICAL HISTORY (patient and notes)

King's Lynn Records

33. 09/10/2008 – A&E referral right shoulder injury, fall from pushbike. X-rays fractured neck of humerus with subsequent surgical management.

34. Noted to be hepatitis C positive, subsequently underwent revision fixation surgery right shoulder.

35. January 2013 – hepatitis C severe fibrosis under hepatologist, hepatitis A antibody positive, hepatitis B negative.

36. August 2012 – recovered from septoplasty surgery. Discharge from ENT.

37. 2007 – hepatitis C positive with previous history of IVDU and excess alcohol. Currently tea-total at that time.

GP provided notes

38. The Wootton's surgery – April 2002 fracture of proximal end of radius left side. Fracture clinic radial head and neck.
39. November 2004 – previous alcohol units 42 per week, currently tea total.
40. April 2006 stopped smoking.
41. April 2010 pain under right great toe, tender plantar surface 1st MTP joint. Plan: support and gel pads.
42. February 2013 – back pain 2 weeks.
43. October 2013 – left knee pain for a few weeks after twisting 6 weeks ago. Plan: refer physio.
44. March 2014 – adoption medical examination, weight 126kg, BMI 32.11.
45. March 2014 – x-ray left knee. Tiny osteophytes present in keeping with minimal degenerative change. Joint space is preserved throughout. Dr Martin Crowe, consultant radiologist. Alcohol 0 units per week. Smoking: ex cigarette smoker.
46. January 2019 – attacked by a prisoner yesterday, fell backwards but no physical injuries.
47. 07/09/2022 – accident and emergency attendance with right fracture proximal femur.
48. 04/11/2022 – last entry, consent given to share patient data with Slater & Gordon Lawyers.
49. 15/04/2021 – hepatology clinic notes frax score for bones 2019 as being low risk.

LOSS DUE TO INJURIES

Work

50. Mr Hartland reports being very motivated to return to his self-employment status of being a full-time psychotherapist. He was off work completely for 3 weeks and then returned in a phased manner, initially with zoom consultations until the 6th week when

he reinstated face to face consultations. Previously he worked in King's Lynn in rented rooms which he has not returned to as yet.

Home

51. Mr Hartland lives in a house with two flights of stairs which he utilises to try and rehabilitate and strengthen his hip. He has not had any physiotherapy in this regard. He is reliant on using a single crutch or stick in his contralateral hand when he is out of doors or needing to walk approximately more than 50 metres. He has no other home adaptations. He continues to strip wash which is a major limitation as his shower is above the bath and he is still unable to lift his leg over safely. He is hoping to be able to do this in the near future.
52. He reports that his wife had to help him with his shoes and socks for approximately 3 months after the accident. He now has trick manoeuvres to manage his socks and now prefers to use slip on type shoes rather than laces.
53. Mr Hartland reports having a small garden at home. He is able to assist with some jobs at waist height but is unable to bend down to the ground. His wife is currently cutting the small lawn.
54. The division of housework and chores was such that it was his role to clean the kitchen weekly, he was unable to do this for 4 months and now does perform this task but takes extra length of time due to his limitations from his right hip.

Aids required

55. None.

Leisure

56. Mr Hartland reports that his main past times and hobbies included playing the guitar which he continues to do as well as cycling. He is no longer able to cycle in terms of loss of confidence but also that he cannot lift his right leg to clear the cross bar.

57. In addition, he is acutely aware of the fact that his playtime with his 7-year-old daughter has significantly changed as a direct result to his right hip as previously discussed.

Driving

58. Mr Hartland reports that he has only recently returned to driving on 12/03/2023 his manual car. He manages this without too much difficulty but is aware that he needs to shift his position within the driving seat to try and get more comfortable due to his right hip pain and stiffness. He has managed his 1-hour journey from King's Lynn today to Cambridge for his consultation with only mild discomfort reported. He reports that he tends to share his driving with his wife which is different from before his accident.

Payment for any treatment

59. None.

EXAMINATION

General

60. Clinical examination for the purpose of this medical report was restricted to the regions of the body, which were thought appropriate to the known facts and nature of the case, and was carried out with the claimant's express consent.

61. Mr Hartland sat throughout the interview with only mild discomfort and having to shift his position within the chair because of right hip discomfort and stiffness. He answered questions opening without overlay or exaggeration.

62. Mr Hartland is of overweight body habitus weighing 107kg and being 193cm in height (BMI: 28.7). He has been actively losing weight to try and help with his recovery and reports being previously heavier. He has no evidence of a postural deformity but

walks with a Trendelenburg gait unaided. Around the house he does not use walking aids as he has furniture to assist, but out of doors and more than 50 metres, he will need to use either a walking stick or his preferred single crutch in his contralateral hand.

63. From his attached clinical photographs and videos of walking and climbing the stairs, he can be seen to have a shortened right lower limb attitude in stance with either his right leg hovering with left leg straight or right knee flexed with right lower limb on the ground. He tends to walk with his right lower limb externally rotated with his Trendelenburg gait.

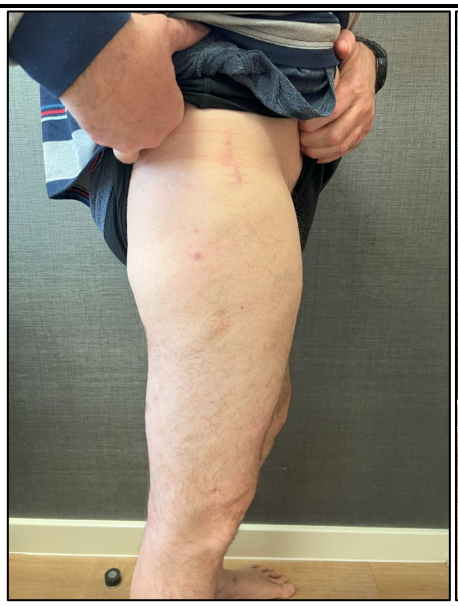
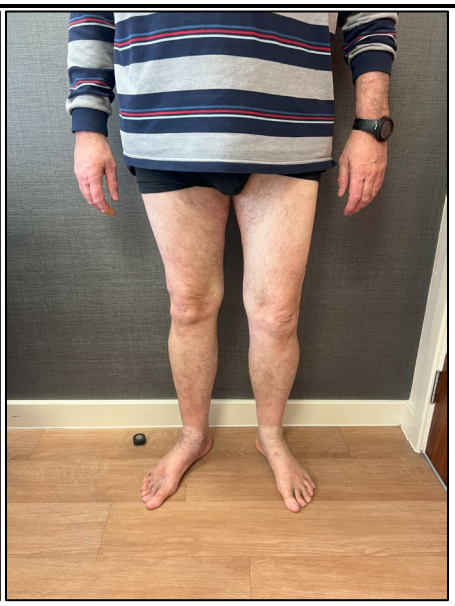
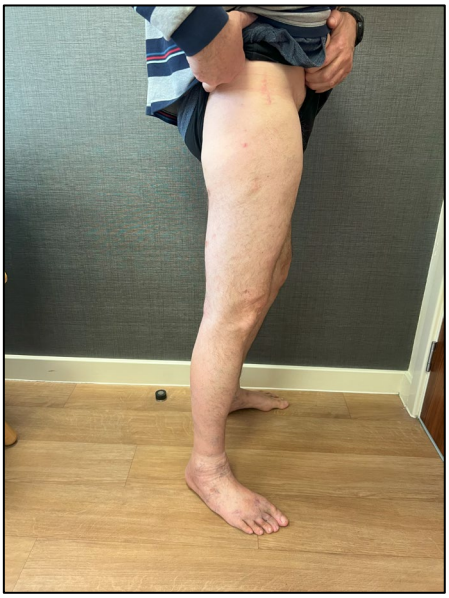
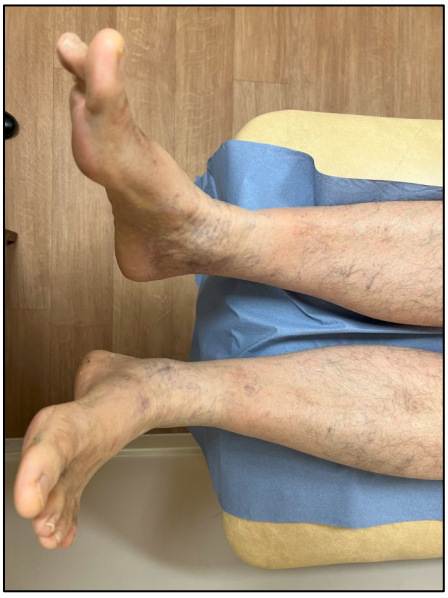
64. On the stairs, he is able to manage reciprocal climbing using his banister in the left hand, descending he finds more difficult due to the lower limb shortening and tends to do this with his right lower limb externally rotated as shown in the video.

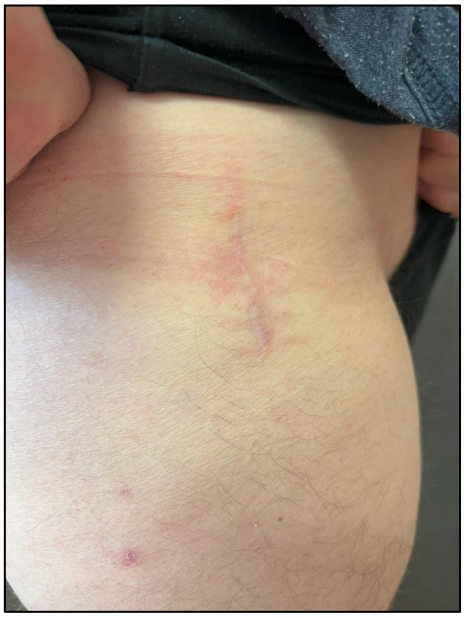
65. Mr Hartland has a number of well healed surgical scars in keeping with his intermedullary hip screw device with no evidence of infection or neuroma. His proximal scar measures 5.5cm in length with the mid scar measuring 3cm in length with the 2 distal locking bolt scars each 12mm in length. In addition, he has scarring to the posterior aspect of his right thigh with discolouration which is directly related to the index accident and blistering at the time post-surgery. He did not have these areas of skin discolouration and scarring previously. They are well healed and no longer causes him any issues.

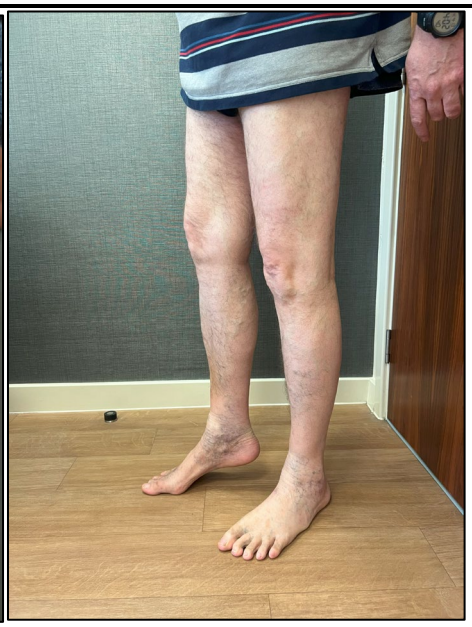
66. Mr Hartland was Trendelenburg positive on the right and negative on the left. Screening the lumbosacral spine was negative. On the couch he tended to lie with shortened right lower leg and externally rotated attitude, it felt abnormal for him to bring his patellar both anteriorly. Accommodating for mild pelvic tilt, his limb length discrepancy is in the region of 3.5cm to the right lower limb shortening. He had good foot pulses and normal lower limb sensation, mild pes planus attitude bilaterally. He had mild asymmetry to his quadriceps circumference bulk measured at 12cm above

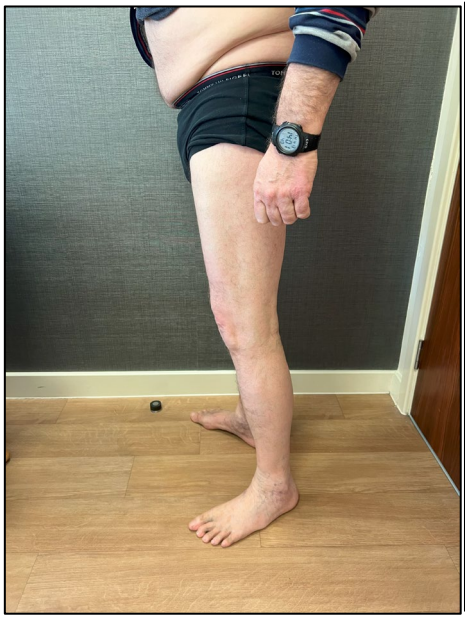
the superior pole of the patellar with his limbs in extension. His right side measured 51cm with the left 52cm. He had grade 4+ out of 5 to hip flexors right side due to discomfort and his other lower limb muscle groups were 5 out of 5. He had normal lower limb sensation other than evidence of meralgia paresthetica to the right. Screening both knees were symmetrical with significant crepitus throughout from full extension and no effusion through to 130 degrees of bilateral knee flexion. Cruciates and collaterals intact with slight varus alignment which was correctable on the couch.

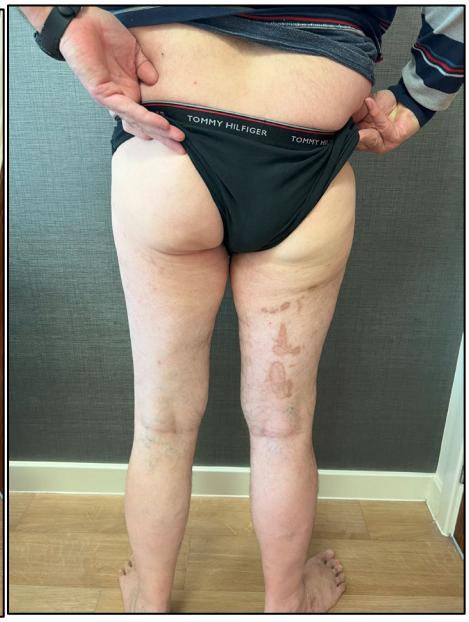
67. When accommodating for his pelvic tilt, his lower limb right sided externally rotated attitude seemed to be in the order of 5-10 degrees when compared to the left side. He was uncomfortable palpating over the distal two scars as well as the mid and less so proximal scar, he had evidence of trochanteric pain syndrome to the right and not the left. The right hip was stiff and uncomfortable compared to the left side. He had no evidence of fixed flexion deformity on Thomas test. He could forward flex his right hip to almost 90 degrees compared to 110 degrees on the left, before he rocked his pelvis. He had no internal rotation to the right hip in the flexed attitude when compared with 5 degrees to the left. The right hip was uncomfortable and FADIR positive. He had 10 degrees of external rotation to the right hip, again uncomfortable in the deep buttock and lesser so anterior groin, compared to 15 degrees on the left. His abduction adduction arch in extended position was in the order of 50 degrees to the right and 50 degrees to the left, again the right side uncomfortable at the extremes.





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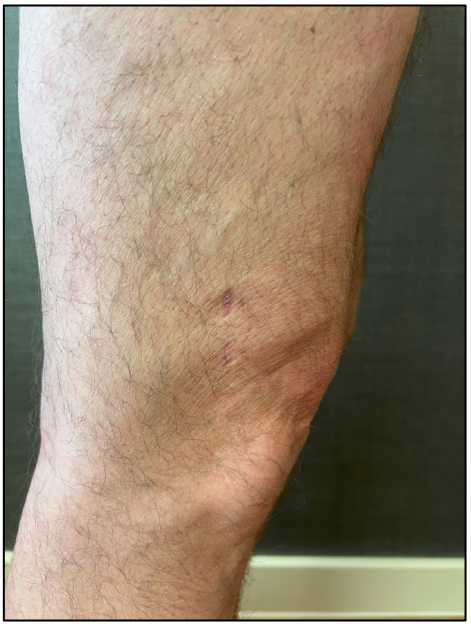
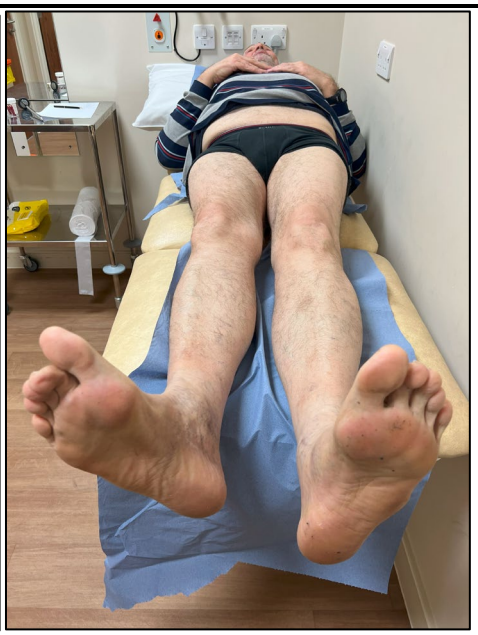
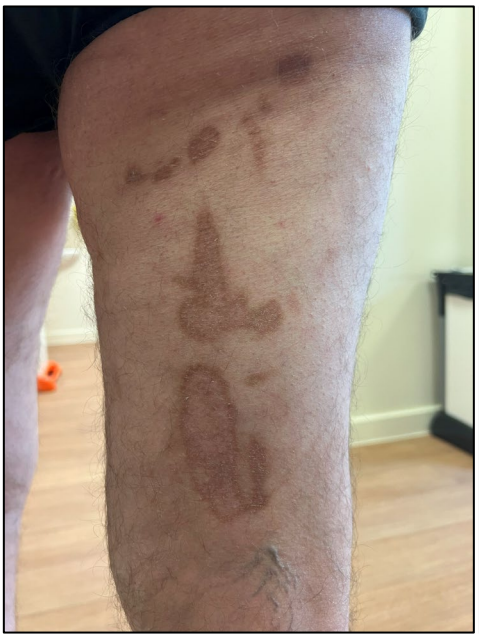
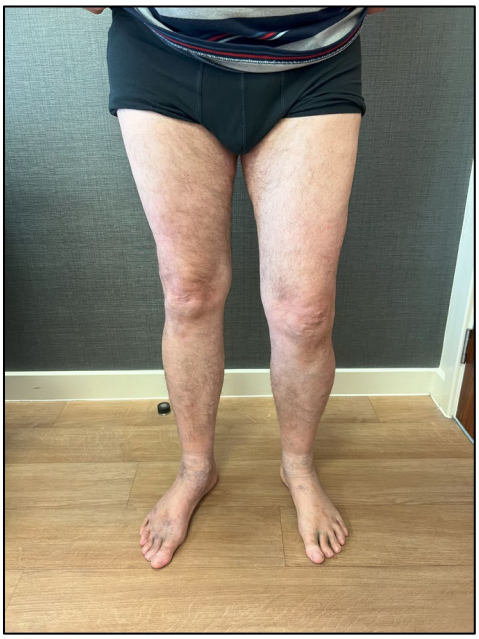
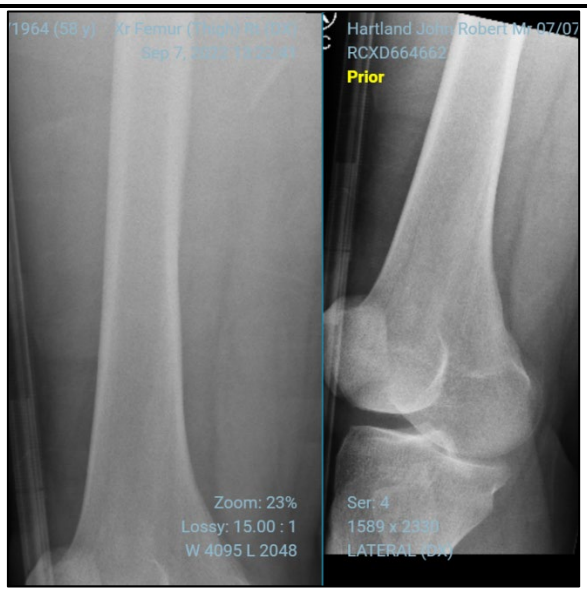





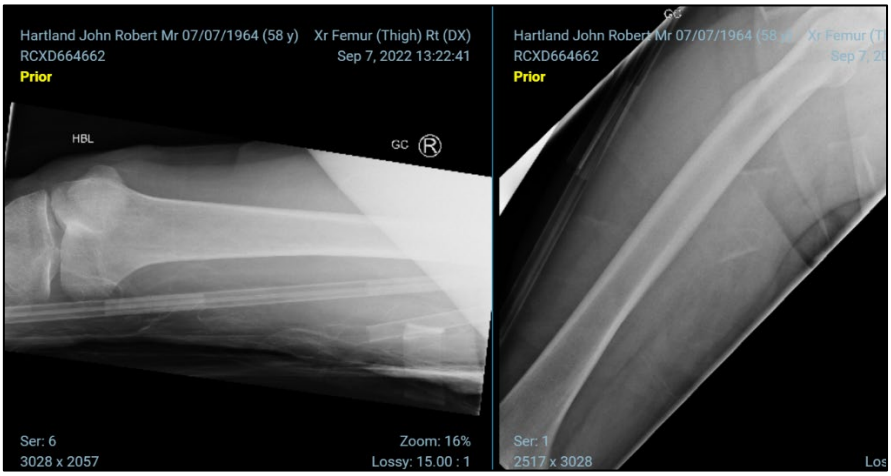
Radiology (X-ray) Review

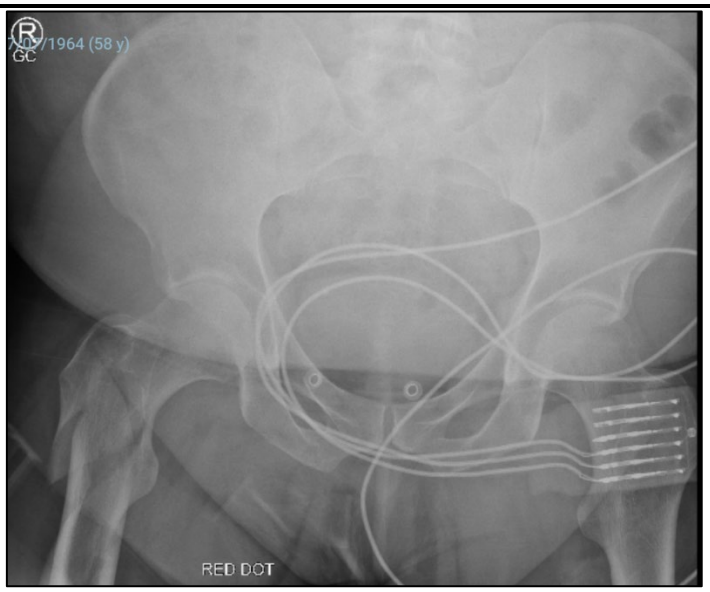
68. X-rays were reviewed as below:

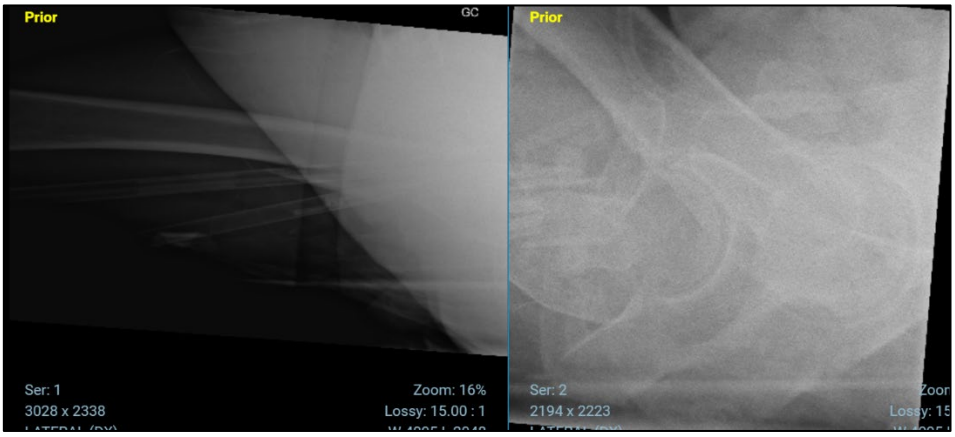
29/11/2022 11:46:17	BONE DENSITOMETRY DXA
22/11/2022 14:14:06	XR FEMUR (THIGH) RT
08/09/2022 15:41:10	FLUORO LOWER LIMB - RIGHT
07/09/2022 13:28:50	XR HIP RT
07/09/2022 13:22:32	XR FEMUR (THIGH) RT
07/09/2022 13:20:51	XR PELVIS

69. 07/09/2022 showing the right sided subtrochanteric proximal femoral fracture.

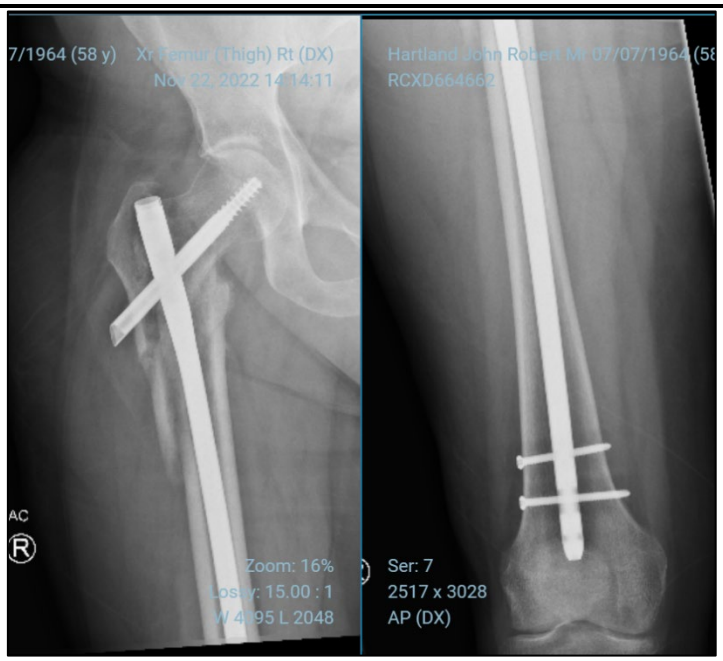

Hartland John Robert Mr 07/07
RCXD664662
Prior
Zoom: 23%
Lossy: 15.00 : 1
W 4095 L 2048
Ser: 4
1589 x 2330
LATERAL (DX)

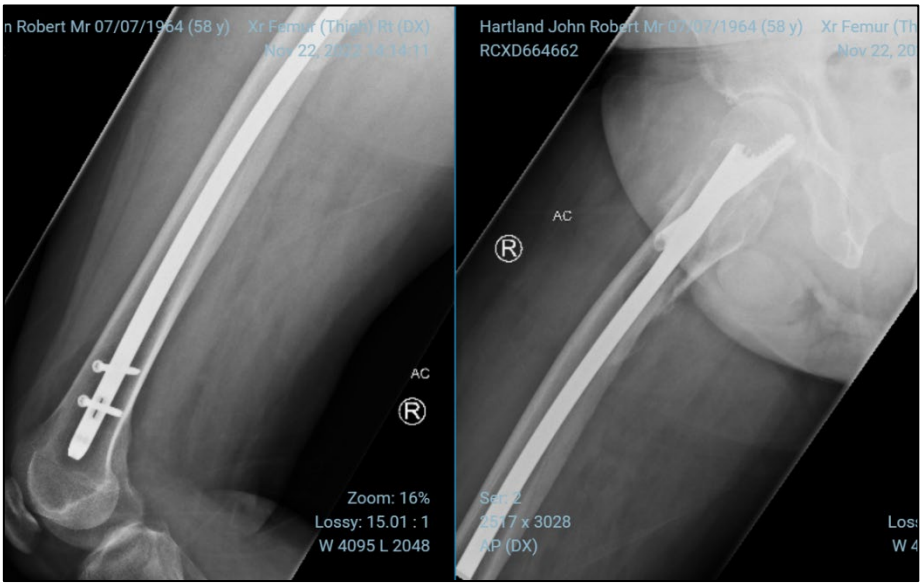

Hartland John Robert Mr 07/07/1964 (58 y)
Xr Femur (Thigh) Rt (DX)
RCXD664662
Sep 7, 2022 13:22:41
Prior
HBL
GC
Ser: 6
3028 x 2057
Zoom: 16%
Lossy: 15.00 : 1
Hartland John Robert Mr 07/07/1964 (58 y)
RCXD664662
Prior
Ser: 1
2517 x 3028



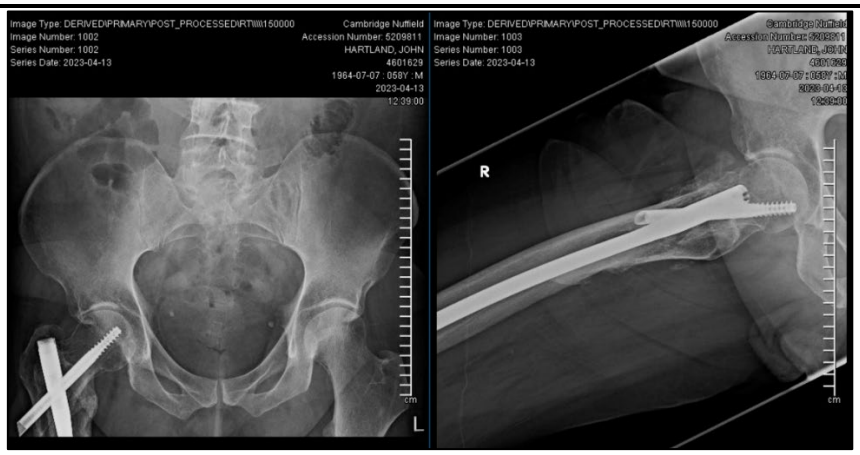


70. Further x-rays of right intermedullary hip screw from 22/11/2022. This x-ray shows the varus fixation of the hip joint when compared to the contralateral left hip morphology. He has an unstable proximal femoral lateral buttress which appears to be a separate fragment allowing further shortening of his femur in this regard.





71. X-rays taken at Nuffield Health Cambridge Hospital on 13/04/2023 – these x-rays show that the proximal femoral fracture has likely united in the aforementioned varus shortened manner. He appears to have progressive osteoarthritic features within the anterior superior quadrant of the right hip with likely early impingement. The lateral hip projection also shows additional likely callus/heterotrophic ossification anteriorly.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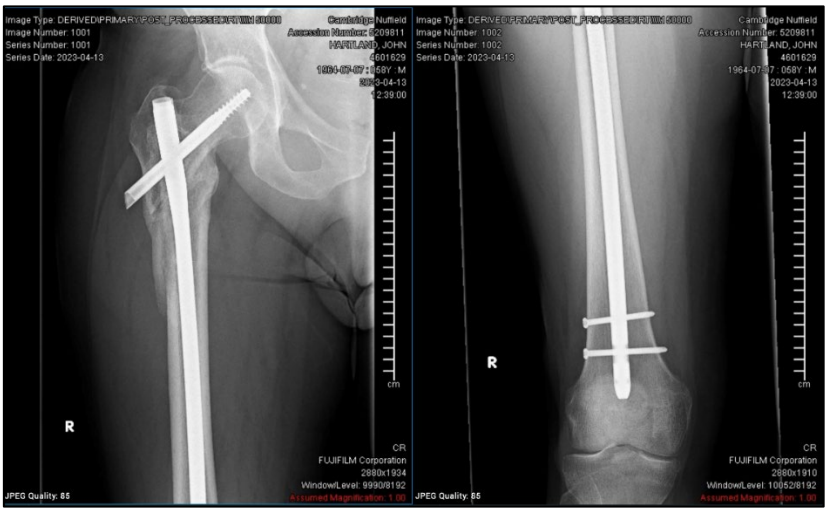
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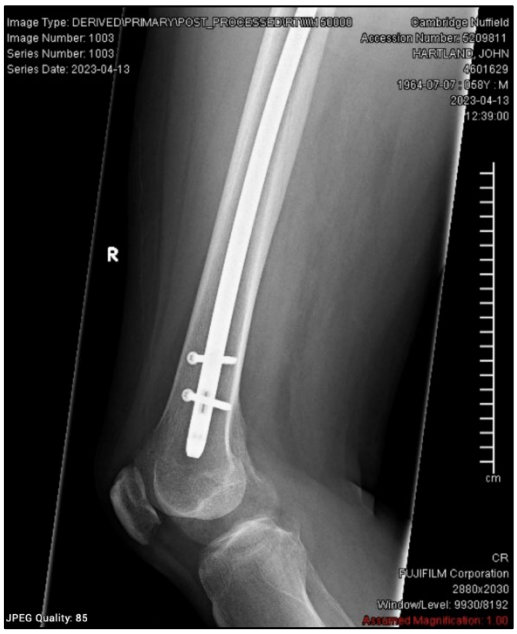
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Window/Level: 9930/8192
JPEG Quality: 85

DIAGNOSIS

72. As a direct result of the accident that happened to Mr Hartland on the 07th September 2022, he sustained:

    (i.) Closed right sided reverse oblique subtrochanteric right proximal femoral fracture necessitating an intramedullary hip screw right side surgery on 08/09/2022.

    (ii.) Soft tissue injury right foot.

    (iii.) Psychological injury.

73. Mr Hartland gave a normal and rational history. There was no attempt to exaggerate. There was no discrepancy between the mechanism of injury and the injuries he sustained. In my opinion the time taken off work was very reasonable, and he was very motivated to return at the early point he did.

OPINION

74. At 7 months post-accident, injury and subsequent right intermedullary hip screw surgery, Mr Hartland is continuing to rehabilitate but has not had any formal physiotherapy since hospital discharge. He is rather stoical and coping with his significant right sided leg length discrepancy which is likely in the order of 3.5cm without any orthotics. His current pain profile, hip stiffness and functional limitations are likely to be progressive with his evident osteoarthritic changes within the right hip, all of which are as a direct result of his index accident.

PROGNOSIS

Injury 1: Closed right sided reverse oblique subtrochanteric right proximal femoral fracture necessitating an intramedullary hip screw right side surgery on 08/09/2022.

75. It is too early to prognosticate completely on this right proximal femoral fracture injury as Mr Hartland is continuing to rehabilitate and will likely plateau his recovery at the 1-year mark. He is due to have an outpatient clinic appointment at this time and on the balance of probability his right hip pain/stiffness and leg length discrepancy will be significant at that time, as well as having progressive osteoarthritic changes within the right hip. He will need to be reviewed at least 12 months post injury and surgery to fully understand the prognosis at that time. I have recommended an MRI scan (metal artefact reduction sequence) to his right hip to understand the cartilage status and soft tissue within/surrounding the right hip.

76. On the balance of probability, he will be likely to need removal of metalwork to the right hip and femur and consideration of a complex primary total hip replacement surgery, likely on the balance of probability, within the next 1-3 years to deal with his likely progressive osteoarthritic features. This is as a direct result of his index accident. For his leg length shortening, equality may be partially or fully reconstructed with his hip replacement surgery at that time. He may be left with a right sided shortened lower limb and need to consider lifelong orthotics in this regard. In the interval period, he should have appropriate physiotherapy as previously discussed as well as orthotic provision to minimise the risk of degenerative features within his lumbosacral spine as well as his large lower limb weight bearing joints with his rather abnormal permanent limp due to his leg length inequality and weakness around his right hip.

Injury 2: Soft tissue injury right foot.

77. Mr Hartland's right foot soft tissue injury, reported to be swollen and bruised for approximately 8-10 weeks post-accident, has completely resolved with no ongoing issues.

Injury 3: Psychology injury.

78. I have recommended a formal psychologist/psychiatrist medicolegal report to which I defer to as this is outside my area of expertise.

Prognosis overall

79. His EQ-5D score prior to the accident was 1 (answers 11111), self-reported score 95%. His EQ-5D score today is 0.536 (answers 42322), self-reported score 80% meaning a 0.464 reduction in disability adjusted life years. i.e., reduction in quality of life since the accident.

80. The EQ5D score is a validated quality of life scoring system, which is commonly used in orthopaedic trauma outcome studies. It has a maximum score of 1, representing the best possible health, a score of 0, is equivalent of death, although the lowest recordable score is in fact -0.59. As a reference, in patients with severe neurological conditions, their EQ5D is reduced by approximately 0.25 disability adjusted life years.

LIFE EXPECTANCY AND LONG-TERM CONSEQUENCES

81. On the balance of probability, Mr Hartland will have no adverse effect on his life expectancy as a direct result of this index accident. His long-term consequences will be appropriately considered at his final medicolegal review opinion.

TREATMENT

82. Due to the NHS current protracted timelines, Mr Hartland should be considered for a private orthotic review as well as physiotherapy as previously discussed. Currently private physiotherapy is approximately £100 per 1-hour session. He will need to have an orthotic quote for private care.

Adaptions / help required to aid in activities of daily living

83. None currently.

PROSPECTS ON THE OPEN JOB MARKET

84. Mr Hartland has been rather stoical at returning to his full-time self-employed status as a psychotherapist. He has no change in his employment and on the balance of probability, as this is mainly a sedentary activity, he will be able to continue this until his UK male age of retirement. With any surgery, such as removal of metalwork or consideration of future complex primary total hip replacement surgery, it is likely that he will need to have a period off work in the order of 2-3 months whereby he will need to have rehabilitation and physiotherapy at that time.

85. Despite Mr Hartland returning to his occupational role, he reports that he is no longer able to hire his rooms in King's Lynn which has had an adverse effect on his overall ability to work and generate income in this manner.

Definition of disability

86. I have been asked to comment on whether the claimant meets the definition of disability. While strictly a question for the court, from a medical point of view, the claimant appears to meet the Ogden definition of disability, in that they have all three of the following conditions in relation to ill-health or disability:

    (i.) They have an illness or a disability which has or is expected to last for over a year or is a progressive illness.

(ii.) The DDA 1995 definition is satisfied in that the impact of the disability has a substantial adverse effect on the claimant's ability to carry out normal day-to-day activities. The claimant's adverse effects are highlighted in the attached document (**appendix ii**)

(iii.) The effects of impairment limit either the kind or the amount of paid work they can do.

EXPERTS DECLARATION

I, Mr Andrew Douglas Carrothers, Declare that

1. I understand that my duty in providing written reports and giving evidence is to help the Court, and that this duty overrides any obligation to the party by whom I am engaged or the person who has paid or is liable to pay me. I confirm that I have complied and will continue to comply with my duty.

2. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.

3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.

4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.

5. I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to points 3 and 4 above.

6. I have shown the sources of all information I have used.

7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.

8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.

9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, including my instructing lawyers.

10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.

11. I understand that;

11.1 My report will form the evidence to be given under oath or affirmation;

11.2 Questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;

11.3 The Court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues in the proceedings, where possible reaching an agreed opinion on those issues and identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;

11.4 The Court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;

11.5 I may be required to attend Court to be cross-examined on my report by a cross-examiner assisted by an expert;

11.6 I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

12 I have read Part 35 of the Civil Procedure Rules, the accompanying practice direction and the Guidance for the instruction of experts in civil claims and I have complied with their requirements.

13 I am aware of the practice direction on pre-action conduct. I have acted in accordance with the Code of Practice for Experts.

STATEMENT OF TRUTH

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.

I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signature……..

Mr Andrew D Carrothers. ***VR, MBChB, MA (Cantab), DiplMC RCSEd, FRCS (Tr & Orth)***

CONSULTANT ORTHOPAEDIC TRAUMA SURGEON CAMBRIDGE

ASSISTANT PROFESSOR, UNIVERSITY OF CAMBRIDGE

Date: 13/04/2023

SOURCES USED TO COMPILE THE REPORT

685 paginated medical notes including ambulance records, GP records and King's Lynn Hospital records.

Mr Andrew D Carrothers
VR, MBChB, MA (Cantab), DipIMC RCSEd, FRCS (Tr & Orth)
Consultant Orthopaedic Surgeon
Assistant Professor, University of Cambridge

Specialist Interest in Pelvic & Acetabular Trauma, complex lower limb injuries and multiply injured patients, primary and revision hip and knee replacement surgeries

Orthopaedic Medicolegal Ltd

CURRICULUM VITAE

Mr Andrew D Carrothers

VR, MBChB, MA (Cantab), DipIMC RCSEd, FRCS (Tr & Orth)

Consultant Trauma & Orthopaedic Surgeon, Cambridge University Hospitals Addenbrookes
Assistant Professor, University of Cambridge

Email: medicolegal@carrothersorthopaedics.co.uk

GMC Number: 6028553, CCT Specialist Register 2012 -

Postgraduate Qualifications:

2022	Assistant Professor, University of Cambridge
2018	MA (Cantab) University of Cambridge
2015	Associate Lecturer, University of Cambridge
2015	Guest Lecturer, Queen Mary University of London Honorary
2014	Senior Clincal Tutor, University of Cambridge Clinical
2012	Fellowship Diploma, University of Toronto
2008	DipIMC RCSEd, Diploma Immediate Care, Royal College of Surgeons Edinburgh
2007	Battlefield Advanced Trauma Life Support Instructor
2003	ALS Instructor

Medical Degree: 2001 MBChB, University of Manchester

Professional Memberships:

- Royal College of Surgeons of Edinburgh
- British Orthopaedic Association
- Canadian Orthopaedic Association (Associate Member)
- Orthopaedic Trauma Society
- British Hip Society
- AO Trauma Fellow (51645)
- Royal Army Medical Corps (V) 551045

CAREER SUMMARY

Andrew is a specialist hip and knee surgeon with specialist interests in pelvic & acetabular trauma surgery, complex lower limb injuries and multiply injured patients, as well as primary and revision hip and knee replacement surgeries.

He is currently a Consultant in Trauma & Orthopaedic Surgery at Addenbrooke's, Cambridge University Hospital NHS Foundation Trust. He also consults and operates at the Spire Cambridge Lea and Cambridge Nuffield Hospitals. In addition he is a Trauma and Orthopaedic Surgeon in the Royal Army Medical Corps (V), having served in both Iraq and Afghanistan. Andrew was trained in the Oswestry Orthopaedic Programme during which time he was awarded the FRCS (Orth) and subsequent CCT in Trauma and Orthopaedic Surgery. His clinical and research interests centre on hip and knee arthroplasty, pelvic and acetabular surgery, lower limb trauma reconstructive surgery, outcome measures following joint replacement, orthopaedic training and education, and medico-legal practice.

Andrew has had extensive exposure to complex primary and revision hip/knee arthroplasty (replacements) as well as high energy polytrauma, in both the civilian and military setting. In particular, he has extensive fellowship-level experience in the management of pelvic and acetabular fractures, periprosthetic fractures and lower limb arthroplasty. Andrew has lectured at international training courses and specialist meetings in the UK, Canada, USA and throughout Europe, including at the Edinburgh International Trauma Symposium. www.trauma.co.uk

With an ongoing research portfolio covering basic science and clinical practice, Andrew has collaborated in studies with university departments and orthopaedic companies. Andrew, an Assistant Professor University of Cambridge, currently has over 80 peer reviewed publications and presentations, both at international and national conferences, on a wide range of arthroplasty and trauma reconstructive topics. He sits on the Editorial Board for the World Journal of Orthopaedics and peer reviews for The Bone & Joint Journal (formerly the British Journal of Bone and Joint Surgery), The Knee and Journal of the Royal Army Medical Corps.

SUMMARY OF PROFESSIONAL EXPERIENCE

Current Post

I am a Consultant Orthopaedic Trauma surgeon at Addenbrooke's Hospital in Cambridge. Addenbrooke's is the Major Trauma centre for East Anglia, and hence deals with the majority of the region's complex trauma. I am currently the CUH Addenbrookes Trauma & Orthopaedic Clinical Governance Lead, having been CUH Addenbrookes Trauma Research Lead since 2019.

I am one of six orthopaedic specialist trauma surgeons with a subspecialist interest in pelvic complex trauma, and I regularly treat patients who have sustained multiple injuries.

I take part in the consultant on call rota for trauma and have a weekly fracture clinic for patients sustaining all types of orthopaedic injuries.

My areas of specialist interest are pelvic and acetabular (hip joint) fractures, open fractures, multiply injured patients and complex lower limb injuries. In addition I am a specialist hip and knee replacement surgeon undertaking in the region of 200 hip and knee replacement primary and revision surgeries each year.

As 1 of the 4 regional pelvic and acetabular surgeons we receive referrals from throughout the East of England (population 5.5million) for advice and definitive management of pelvic and acetabular fractures and complex trauma through our webreferral form www.cambridgepelvicsurgery.co.uk

I have a significant academic interest in pelvic and acetabular fractures and as UK Chief Investigator of the NIHR NHS AceFIT Feasibility trial I have a £350,000 grant awarded. This is a randomised trial comparing non-operative management,vs fixation, vs fix and replace for older patients who have sustained acetabular fractures.

I have been the principal investigator in Cambridge for National trauma trials including:
AIM – A prospective trial into the management of ankle fractures in older patients
FiXDT – A prospective randomised trial into the management of distal tibial fractures

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MEDICO-LEGAL EXPERIENCE

I undertake, on average, 50 personal injury medicolegal reports a year.

In recent years a large proportion of my instructions are related to pelvic and acetabular fractures, complex lower limb injuries, and patients who have sustained multiple injuries.

I still regularly treat, as well as report on patients sustaining single limb injuries.

I DO NOT prepare reports on whiplash, spinal injuries or back pain.

My ratio of claimant to defendant work is approximately 80:20.

I also report on around 10-15 clinical negligence cases per year.

PAPERS PUBLISHED

1. Sequential low molecular weight heparin and rivaroxaban for venous thromboprophylaxis in pelvic and acetabular trauma.

Jos Crush, Matthew Seah, Daud Chou, Jaikirty Rawal, Peter Hull, Andrew Carrothers

Archives of Orthopaedic and Trauma Surgery

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Published:May 03, 2021DOI:https://doi.org/10.1016/j.injury.2021.04.066

3. Factors associated with mortality in older patients sustaining pelvic or acetabular fractures.

Anna Harrison, Alejandro Ordas-Bayon, Mukai Chimutengwende-Gordon, Mary Fortune, Daud Chou1, Peter Hull, Andrew Carrothers, Jaikirty Rawal

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4. Pushing the Surgical Limits: Primary Total Knee Arthroplasty Using Rotational Prosthesis in a 96- Year-Old Lady with End-Stage Osteoarthritis

Natasha G , George Hourston , Azeem Thahir , Andrew Carrothers

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5. Dynamic Hip Screw Fixation of Subtrochanteric Femoral Fractures

Acepted Jan 2021. No. EJOS-D-20-00990R1
European Journal of Orthopaedic Surgery & Traumatology

Z Arshad, A Thahir, J Rawal, P Hull, A Carrothers, M Krkovic, D Chou.

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Journal of Clinical Orthopaedics and Trauma

Addenbrookes Cambridge University Hospital NHS FT

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7. The impact of frailty in major trauma in older patients.
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9. Pulmonary Embolism following Complex Trauma: UK MTC Observational Study
Thomas E Glover, Joanna E Sumpter, Ari Ercole, Virginia Newcombe, Andrew Carrothers, David K Menon, Ronan O'Leary
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10. An advancement of the Harrington technique for reconstruction of pathological fractures of the acetabulum
R Coomber, D Lopez, AD Carrothers
Cambridge University Hospitals NHS Foundation trust, Cambridge, United Kingdom
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11. Dual mobility total hip arthroplasty: identification and reduction technique.
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R Coomber, S Dotivala, M Chowdhry, A Carrothers
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16. Adult-onset Hypophosphatasia diagnosed following Bilateral Atypical Femoral Fractures in a 55-year old woman.

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Elizabeth K Tissingh, Abigail Johnson, Joseph Queally, Andrew D Carrothers

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AD Carrothers.

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Accepted JOT 558R2 August 2016

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B Akinola, B Quansah, T Gouliouris, AD Carrothers

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22. Fix and replace; an emerging Paradigm for Treating Acetabular Fractures

CG Murphy, AD Carrothers

Accepted Clinical Cases in Mineral and Bone Metabolism. July 2016

23. The Outcome Following Hip Fracture for Warfarinised Patients: A Retrospective Observational Study

J Lawrence, AD Carrothers

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24. Cambridge University Hospitals Early Appropriate Care Pathway: Are we making appropriately guided decisions?

W Wynell-Mayow, B Guevel, B Quansah, R O'Leary, AD Carrothers

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M Seah, CG Murphy, S Mconald, AD Carrothers

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CG Murphy, J Gill, AD Carrothers, P Hull

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J Arthroplasty. 2014 Jul;29(7):1463-7. doi: 10.1016/j.arth.2013.02.001. Epub 2014 Apr 24.

36. Reducing mortality for high risk surgical patients in the UK.
BA Rogers, AD Carrothers, C Jones.

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A Jaiswal, RE Gilbert, S. Kumar, AD Carrothers, JH Kuiper, JB Richardson.
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39. Lagging the Locking Compression Proximal Femoral Plate 4.5/5.0 Synthes(R) to the Proximal Femur. (Technical Tip)
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40. Birmingham Hip Resurfacing in patients who are seventy years of age or older.
AD Carrothers, RE Gilbert and Prof JB Richardson.
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43. The St Leger total knee replacement – a 10 year clinical and radiological assessment. RE Gilbert, AD Carrothers, J Gregory, M Oakley.
The Knee. 2009;16(5):322-325.

44. Surgical training opportunities within the Royal Army Medical Corps.
AD Carrothers. JCHST Dec Supplement 2005

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Pre Interview Medicolegal Questionnaire

Patient: John Hartland **Created on:** 18 Mar 2023

Last Update: 18 Mar 2023 **Created by:**

[]

Please take some time to complete this as fully as possible
Please bring the completed form to your appointment with Mr Carrothers

Personal Details

Name:	JohnHartland
Address:	3 North Star Court, King's Lynn, Norfolk PE30 2NF
Date of birth:	07/07/1964
Age:	58
Occupation:	Psychotherapist
Hours worked per week:	40
Marital status:	Married
No. of dependant children:	1
Left or right handed:	Right

The Accident

Date of the accident:	07/09/2022

Time of the accident:	around 9:45 am
Describe the accident:	He opened his car door and knocked me of my push bike
FOR OFFICIAL USE ONLY	
What were your injuries:	Broken femur. Not sure if my hip joint to femur was also broken. The box below "What severity of pain did you have: (Mark below for each injury"(does not appear to work?

What severity of pain did you have: (mark below for each injury)

Did an ambulance attend:	yes
Did you go to hospital:	y
Which hospital:	QEH, Kings Lynn
What treatment was given:	took the bone marrow out of my femur and put a long rod down with two nails at the bottom near the near and I think two at the top plus a long pin at the hip
GP treatment	
Did you attend your GP:	no
How often:	
What treatment was given:	
Physiotherapy	
Did you have physio:	overy day while I was in hospital for 13 days
How often:	daily
What treatment was given:	

Other treatment

What other treatment was received for your injuries:

All injuries have an acute phase (worse initially), a recovery phase and sometimes a chronic phase (symptoms become static and don't seem to recover). Symptoms can be mild, moderate or severe.

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How long and how severe did each stage last for each of your injuries in weeks/months/years?

Acute phase:	6 weeks
Recovery phase:	6 months
Chronic phase:	ongoing. Again unable to fill in the box below "What severity of pain did you have: (mark below for each injury) or the box following: "Use diagram if helpful"

What severity of pain did you have: (mark below for each injury)

Current symptoms

Use diagram if helpful

Can you describe your symptoms in terms of:

Areas involved (circle as appropriate):	dull, tingly
Type of pain:	tingling

Pins & needles?

Provoking symptoms:	When going to bed

How is the pain relieved:

Psychological symptoms

Have you suffered any the following mental effects:

Tearfulness	Yes
Anxiety	Yes
Depression	Yes
Flashbacks	No
Nightmares	No
Panic attacks	No
Mood swings	No
Irritable	Yes

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Previous Conditions

Have you been injured in these areas before?	no
Even if not injured, have you had any previous symptoms in these areas:	no
Have you had a significant time off work with illness before (describe):	no
What other medical conditions do you have:	Fatty Liver and scaring
What medication do you take regularly:	Calcium and vitamin D

Work	
Is this the same job you had at the time of the accident (if not describe):	y
How much time did you have off work:	three weeks
Did you return to work fulltime/ phased return	phased
Did your injury affect your ability to work:	Need
Did you need help from colleagues at work:	
Have you returned to driving (if you drive):	yes on 12/03/2023
FOR OFFICIAL USE ONLY	
Homelife	

Did you require help with the following activities (If yes, how long for)

Bathing	
Showering	Yes, I find it hard to geting the shower so strip wash only
Dressing	Sometimes getting my socks on
Hoovering	
Washing up	
Laundry	

Shopping	
Stairs	
Gardening	Yes, wife now has to do it
Sleep	
Do you live alone:	no
Who helped you:	wife
Why did you need help:	
Hobbies and Social Life	
What are your hobbies:	Guitar, cycling
How long did you avoid them? Have you started:	No longer cycle
Why did you avoid them:	I do not feel confident enough to cycle
Has your social life been affected by the accident:	Yes, unable to get about as not cycling or driving
In what other ways have you been affected by the accident:	
FOR OFFICIAL USE ONLY	
Signature:	

Date: 18/03/2023

Pre-accident EQ-5D-5L

Patient: John Hartland **Created on:** 18 Mar 2023

Last Update: 18 Mar 2023 **Created by:**

[]

Please complete the form as to how you are ***BEFORE*** your accident

Patient Name:	JohnHartland
DOB:	07/07/1964
Date of Completion:	18/03/2023

Health Questionnaire

Under each heading, please tick the ONE box that best describes your health **PRIOR to your accident**

MOBILITY pre-accident	
SELF-CARE pre-accident	I have no problems washing or dressing myself
USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities) pre-accident	I have no problems doing my usual activities
PAIN / DISCOMFORT pre-accident	I have no pain or discomfort
ANXIETY / DEPRESSION pre-accident	I am not anxious or depressed

Health Scale pre-accident

We would like to know how good or bad your health was ***BEFORE*** your accident.

This scale is numbered from 0 to 100.

100 means the best health you can imagine. 0 means the worst health you can imagine.

Mark an X on the scale to indicate how your health was.

Now, please write the number you marked on the scale in the box below.

YOUR HEALTH PREVIOUSLY = 95

EQ-5D-5L

Patient: John Hartland

Created on: 18 Mar 2023

Last Update: 18 Mar 2023

Created by:

[]

Please complete the form as to how you are TODAY

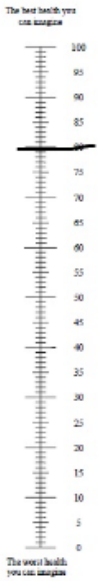
Patient Name:	JohnHartland
DOB:	07/07/1964
Date of Completion:	18/03/2023

Health Questionnaire

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY	I have severe problems in walking about
SELF-CARE	I have slight problems washing or dressing myself
USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)	I have moderate problems doing my usual activities
PAIN / DISCOMFORT	I have slight pain or discomfort
ANXIETY / DEPRESSION	I am slightly anxious or depressed

Health Scale



We would like to know how good or bad your health is TODAY.

This scale is numbered from 0 to 100.

100 means the best health you can imagine. 0 means the worst health you can imagine.

Mark an X on the scale to indicate how your health is TODAY.

Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = 80

New Disability

Patient: John Hartland

Created on: 18 Mar 2023

Last Update: 18 Mar 2023

Created by:

Please answer yes or no to the statements below.

Unable to travel short journeys as a passenger in a car.	No
Unable to walk other than at a slow pace or with jerky movements.	Yes
Difficulty in negotiating stairs.	Yes
Unable to use one or more forms of public transport.	No
Unable to go out of doors unaccompanied.	No
Loss of functioning in one or both hands	No
Inability to use a knife and fork at the same time	No
Difficulty in pressing buttons on a keyboard	No
Unable to feed or dress oneself.	No

Unable to pour liquid from one vessel to another except with unusual slowness or concentration.	No
Frequent or regular loss of control of the bladder or bowel.	No
Unable to lift, carry or otherwise move everyday objects (for example, books, kettles, light furniture) -	No
Unable to pick up a weight with one hand but not the other	No
Unable to carry a tray steadily.	Yes
Unable to speak (clearly) with others	No
Taking significantly longer to say things.	No
Being unable to hear without the use of a hearing aid.	No
Unable to understand speech under normal conditions or over the telephone.	No
Being unable, while wearing spectacles or contact lenses to pass the standard driving eyesight test, or to read newsprint.	No
Intermittent loss of consciousness or confused behaviour.	No

Inability to remember names of family or friends	No
Unable to write a cheque without assistance	No
Unable to follow a recipe.	No
Exhibiting reckless behaviour – for example putting yourself or others at risk.	No

DRI

Patient: John Hartland

Created on: 18 Mar 2023

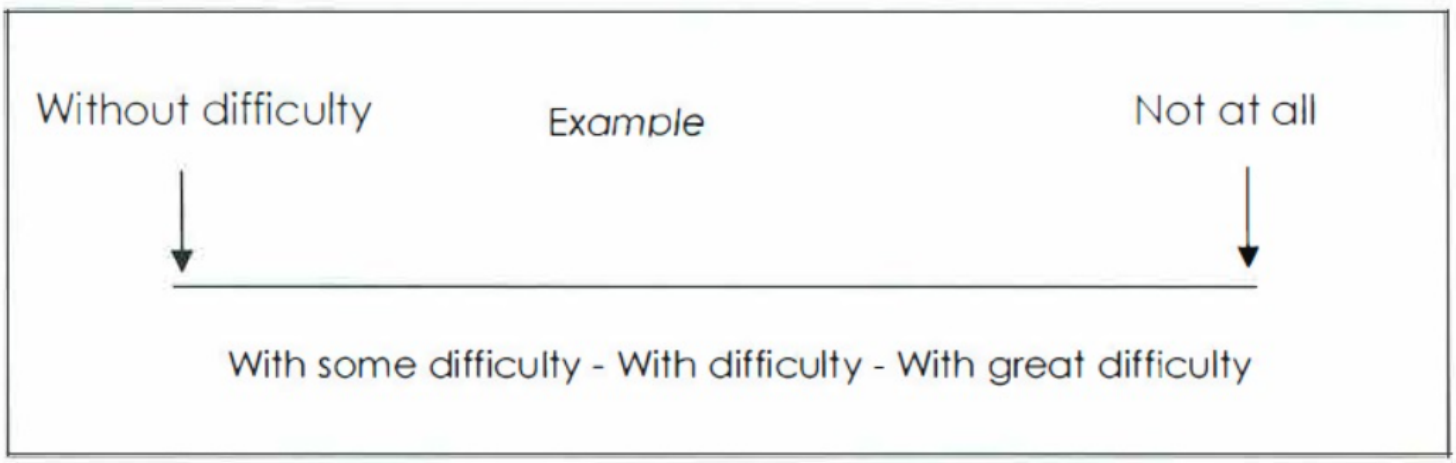
Last Update: 18 Mar 2023

Created by:

[]

Patient Name:	JohnHartland
DOB:	01/03/1964
Date of Completion:	18/03/2023

Disability Rating Index



How do you manage the following activities?

After each question, please mark ONE POINT on the line

Please answer ALL questions

Dressing (without help)	1 With some difficulty
Out-door walks	1 With some difficulty

Climbing stairs	1 With some difficulty
Sitting longer time	0 Without difficulty
Standing bent over a sink	1 With some difficulty
Carrying a bag	1 With some difficulty
Making a bed	1 With some difficulty
Running	4 Not at all
Light work	2 With difficulty
Heavy work	4 Not at all
Lifting heavy objects	4 Not at all
Participating in exercise/sports	3 With great difficulty

SALEN BA, ET AL. THE DISABILITY RATING INDEX: AN INSTRUMENT FOR THE ASSESSMENT OF DISABILITY IN CLINICAL SETTINGS.

J CUN EPIDEMIOL 1994;47(12): 1423-35.

The Foot & Ankle Disability Index (FADI) Score

Patient: John Hartland **Created on:** 18 Mar 2023

Last Update: 18 Mar 2023 **Created by:**

[]

COMPLETED DATE:	18/03/2023
Patient's name (or ref	John Hartland

Please answer every question with one response that most closely describes your condition within the past week. If the activity in question is limited by something other than your foot or ankle, mark N/A

1. Standing	Slight difficulty
2. Walking on even ground	Slight difficulty
3. Walking on even ground without shoes	Slight difficulty
4. Walking up hills	Moderate difficulty
5. Walking down hills	Slight difficulty
6. Going up stairs	Slight difficulty
7. Going down stairs	Slight difficulty
8. Walking on uneven ground	Moderate difficulty
9. Stepping up and down curves	No difficulty at all

10. Squatting	Moderate difficulty
11. Sleeping	Slight difficulty
12. Coming up to your toes	Slight difficulty
13. Walking initially	No difficulty at all
14. Walking 5 minutes or less	Slight difficulty
15. Walking approximately 10 minutes	Slight difficulty
16. Walking 15 minutes or greater	Slight difficulty
17. Home responsibilities	Slight difficulty
18. Activities of daily living	Slight difficulty
19. Personal care	Slight difficulty
20. Light to moderate work (standing, walking)	Slight difficulty
21. Heavy work (push/pulling, climbing, carrying)	Moderate difficulty
22. Recreational activities	Moderate difficulty
23. General level of pain	MILD
24. Pain at rest	MILD
25. Pain during your normal activity	NO PAIN
26. Pain first thing in the morning	NO PAIN

Thank you very much for completing all the questions in this questionnaire.

The Foot & Ankle Disability Index (FADI) Score is

Oxford Hip Score (OHS)

Patient: John Hartland **Created on:** 18 Mar 2023

Last Update: 18 Mar 2023 **Created by:**

[]

Prior to completing the questionnaire please complete the following:-

Your Name:	John Hartland
Today's Date:	18/03/2023
On which side of your body is the affected hip for which you are receiving treatment?	Right

If you said 'both', please complete the first questionnaire thinking about the right side. A second questionnaire, for the left side, will follow.

PROBLEMS WITH YOUR HIP

Tick (✓) one box for every question.

1. During the past 4 weeks...

How would you describe the pain you usually have from your hip?	Very mild

2. During the past 4 weeks...

Have you had any trouble with washing and drying yourself (all over) because of your hip?	Very little trouble, Moderate trouble

3. During the past 4 weeks...	
Have you had any trouble getting in and out of a car or using public transport because of your hip? (whichever you tend to use)	Very little trouble, Moderate trouble
4. During the past 4 weeks...	
Have you been able to put on a pair of socks, stockings or tights?	With little difficulty
5. During the past 4 weeks...	
Could you do the household shopping on your own?	With moderate difficulty
6. During the past 4 weeks...	
For how long have you been able to walk before pain from your hip becomes severe? (with or without a stick)	No pain/More than 30 minutes
7. During the past 4 weeks...	
Have you been able to climb a flight of stairs?	With little difficulty
8. During the past 4 weeks...	
After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?	Not at all painful
9. During the past 4 weeks...	
Have you been limping when walking, because of your hip?	All of the time
10. During the past 4 weeks...	

Have you had any sudden, severe pain - 'shooting', 'stabbing' or 'spasms' - from the affected hip?	Some days
11. During the past 4 weeks...	
How much has pain from your hip interfered with your usual work (including housework)?	Not at all
12. During the past 4 weeks...	
Have you been troubled by pain from your hip in bed at night?	Some nights

Finally, please check back that you have answered each question.

Thank you very much.

Majeed Score

Patient: John Hartland

Created on: 18 Mar 2023

Last Update: 18 Mar 2023

Created by:

Questions in relation to your pelvis	
Pain	Slight, occasional or no pain - 30
Work	Same job, same performance - 20
Sitting	Uncomfortable - 8
Sexual intercourse	Uncomfortable - 3
Standing	One stick - 10
Gait unaided	Moderate limp - 8
Walking distance	One hour with a stick limited without - 8

Sexual and Urinary Dysfunction Questionnaire for Pelvic Fractures

Patient: John Hartland

Created on: 18 Mar 2023

Last Update: 18 Mar 2023

Created by:

[]

Patient Name:	JohnHartland
Date Completed:	18/03/2023
Appendix 1 **Questionnaire**	
1a. Pain on passing water (please choose one of the following options)	I have no pain on passing water
1b. Control when passing water (please choose one of the following options)	I have had no accidents with passing water (ie, I can control when I urinate)
1c. Urine flow (please choose one of the following options)	I can start and maintain a good stream of urine without difficulty
1d. Frequency of passing water (please choose one of the following options)	During the day, I urinate as often as I used to compared with before my injury
1e. Passing water at night (please choose one of the following options)	I get up at night as often as I used to (before my injury) to urinate

1f. Overall, how much of a problem would you say passing water has been since your injury? (please choose one of the following options)	Very small problem
1g. Have you had to see a specialist with respect to your bladder/passing water?	No
If yes, have you been prescribed any medications or had any surgery or investigations (please detail below)?	
2. Sexual function	I have had significant new problems with sexual function since my injury
2a. Over the past month	I have been easily aroused sexually
2b. Sexual function (males only): over the past month	
I have had erections (morning erections or erections on awakening)	b. Approximately three times per week
2c. Sexual function (males only):	
2d. Sexual function (females only): over the past month	
2e. Over the past month	I have had orgasms/ejaculations as often as I have wanted
2f. How would you rate your level of sexual desire compared with before your injury?	Unchanged
2g. Overall, how much of a problem would you say your sexual function has been since your injury?	Very small problem

2h. Have you had to see a specialist with respect to your sexual function?	No
If yes, have you been prescribed any medications or had any surgery or investigations (please detail below)?	

Mr Carrothers Consent Form

Patient: John Hartland

Created on: 18 Mar 2023

Last Update: 18 Mar 2023

Created by:

Full Name:	John Hartland
Address:	3 North Star Court, King's Lynn, Norfolk PE30 2NF
Undertakings:	
I understand that Mr Andrew Carrothers, Consultant Orthopaedic & Trauma Surgeon, will carry out a full examination and may reproduce photographs, X-ray images and any video clips taken within the Report produced for Court use.	Yes
The entire consultation will also be video recorded and saved securely.	Yes
I am also aware that he will have full access to my medical and radiological records, the data of which will be stored securely, for the preparation of the medicolegal report for Court use.	Yes

I understand that this is to aid the Court, to ensure full transparency. Full details of how my data is stored is in the enclosed GDPR document which I have read and understood.	Yes
Consent:	I do give consent for the above for the purpose of a Medicolegal Report for Court use
Signature:	
Date:	18/03/2023
Print Name:	John Hartland
Full name of Parent/Guardian	

(if consenting for a minor or a person with a decision-making disability)