**Please be aware that this is an anonymised copy of what was a real report and litigation has ended. The names in this report are all false.**

# Medical Report by Dr Alastair H Bint

**To the Court**

**Dated**
14th February 2011

**Area of Expertise**
General Practice

**On behalf of the Defendant**
Mr Hugh Blue,
XXXXXXXXXX,
XXXXXXXXXX,
XXXXXXXXXX

**Instructing Solicitors**
McMillan Williams
XXXXXXXXXX
Ref XXXXXXXXX

**Subject**
Medical assessment for Crown Court

**Written by**
Dr Alastair Bint, St Lukes Surgery, Warren Road, Guildford, GU1 3JH

## Contents



## Appendices

# Report

## 1. Introduction

**1.01** The Expert

I am Dr Alastair Halford Bint. My specialist field is General Medical Practice. Full details of my qualifications and experience entitling me to give expert opinion evidence in this case are in appendix 1.

**1.02** The instructions and issues to be addressed

To perform a medical assessment of Mr Blue and to comment on the various medical conditions and disabilities present on the 4th December 2009, medication he was receiving and possible side effects of the medication, with particular reference to possible arthritis and the mobility difficulties that this condition may have presented.

**1.03** Documents I have examined

Full GP records

Letter of Instruction dated 10th February 2011

Report from Counsel Mr Mark Kelly of No 5 Chambers dated 29th August 2010

**1.04** I examined Mr Hugh Blue on the 14th February 2011 in my consulting room at XXXXXX.

**1.05** Structure of this report

This report will set out each relevant medical condition present and will detail four aspects of that condition, namely the documentary evidence of that condition from the medical records, Mr Blue's recollection of the symptoms he had present in December 2009, my examination findings on the 14th February 2011 and my opinion on these with reference to the allegations.

## 2. Summary of my conclusions

**2.01** In December 2009 Mr Blue was suffering widespread osteoarthritis and a painful inguinal hernia that would have made bending or kneeling painful but not physically impossible.

**2.02** Mr Blue was also suffering bilateral carpal tunnel syndrome and osteoarthritis causing pain to the base of his thumbs and some numbness and tingling in both hands, making fine movements of his hands like writing or operating the combination lock of a safe difficult but not impossible.

**2.03** On the night in question, the 4th December 2009, Mr Blue had taken more than his usual amount of whisky that evening and had taken double his normal dose of tranquiliser medication, Lormetazepam, mainly because of pain from his inguinal hernia. This is likely to have made him more drowsy than normal and impaired his judgement. An expert clinical pharmacologist should be instructed to comment further on this.

## 3 Medical conditions present

### 3.01 Widespread Osteoarthritis

(a) Documentary evidence from Medical Records

The GP records including reports from various Consultant Specialists, detail osteoarthritis in Mr Blue's lower back, hands, especially base of thumbs, knees and neck dating back to at least 2002. Occasional left sided sciatica was also noted. He has received long term painkillers and various other interventions for example physiotherapy and acupuncture. During December 2009, the GP records show that Mr Blue was regularly receiving the painkillers, Peroxicam and Tramadol. His GP has recorded in a letter in September 2010 to the Solicitors, that Mr Blue requires the use of a walking stick and that the GP would not expect Mr Blue to be able to run more than a few steps at a time.

(b) Mr Blue's recollection of his symptoms in December 2009

Mr Blue could only walk with the aid of a stick, he had trouble writing and could only carry objects with one hand. He was mobile outside primarily with the use of a sit on disabled scooter. He had been using a stick since 2005 and had been retired on medical grounds in 2006. His pain in his back and knees made it difficult to bend down or kneel down however the Main problem preventing him from doing so was his inguinal hernia.

(c) My examination findings on 14th February 2011

There are clear signs of osteoarthritis in the lower back, knees and hands, with Mr Blue walking with an antalgic gait, using a stick and needing help to stand up from a chair. He uses support braces on his knees and right wrist. The prognosis for this condition is poor in that the osteoarthritis is often progressive until various joints wear out to the point that they need replacement. The mainstay of control however is good pain relief.

(d) Relevance to allegations in this case

Mr Blue is significantly affected with osteoarthritis and was clearly affected in December 2009. This would mean that certain activities of daily living could have been performed and others couldn't. Some would be performed slower that a normal person and certain fine movements especially of the hands would be performed with difficulty. With relevance to this case, Mr Blue would have had difficulty bending or kneeling down and with operating the combination lock of a safe, but without the ability to be able to examine Mr Blue on the particular day in question, I cannot say with any degree of certainty whether he could or could not perform these particular tasks.

**3.02 Anxiety and depression**

(a) Documentary evidence from Medical Records

In December 2009, Mr Blue had a long history detailed in his medical records of anxiety and depression primarily causing significant insomnia. The medical records confirm that as a consequence Mr Blue was taking night- time sedation in the form of Lormetazepam one half of a 1 milligram at night or Temazepam one half of a 10milligram tablet at night.

Dated 9th December 2009, the GP records record, '*the night of the armed raid Mr Blue had 3 double shots of whisky through the evening and a 1mg Lormetazepam tablet, taken to A and E as was drowsy but soon came round, unable to remember series of events of Friday night but slowly memory come together.'*

(b) Mr Blue's recollection of his symptoms in December 2009

On the 4th December 2009, Mr Blue had been in a lot of pain from his inguinal hernia and he consumed 3 large whiskies (when his normal consumption would be two, one with dinner and one later in the night). Mr Blue also took a whole 1mg Lormetazepam tablet (as opposed to his normal half a tablet). He knows that he took this tablet at 10.50 pm that night because his wife gave it to him as she helped him into bed, lifting his legs into bed for him.

(c) My examination findings on 14th February 2011

Mr Blue continues to require night sedation and continues to suffer significant amounts of anxiety and mood disturbance.

(d) Relevance to the allegations in this case

Lormetazepam is a member of the group of drugs called benzodiazepines. The particular combination of alcohol and benozdiazepine medication is well known to impair judgement and slow motor skills. On the particular night in question it appears that Mr Blue took more than his normal amount of whisky and a higher than his normal dose of lormetazepam and I would expect that this would have made him very drowsy. There have been case reports of patient's sleep walking and having amnesia of events whilst under the influence of alcohol and benzodiazepines although it is much more likely that this combination simply put him into a heavy sedated sleep. An expert Clinical Pharmacologist should be instructed to comment on this further on the particular effects to be expected from this combination.

**3.03 Inguinal hernia**

(a) Documentary evidence from Medical Records

From the six months prior to December 2009 Mr Blue was complaining of pain in the left groin area. He eventually had an inguinal hernia diagnosed on scan on the 4th December 2009 and later went on to have it operated upon.

(b) Mr Blue's recollection of his symptoms in December 2009

On the 4th December 2009 Mr Blue recalls that he had been to hospital to have tests for his inguinal hernia. These tests, including a CT scan whilst 'straining' and an examination during which a doctor pushed fingers into his groin, had caused pain. The hernia itself caused pain especially when he was bending over or bending down and it was particularly bad that day after these tests. He claims that this pain was to a degree that he would not have been able to bend or kneel down to use a safe.

(c) My examination findings on 14th February 2011

There is a left groin scar in keeping with an open inguinal hernia mesh repair.

(d) Relevance to the allegations in this case

It is unusual for an inguinal hernia to cause the amount of pain that Mr Blue describes. In the vast majority of cases an inguinal hernia causes a bit of discomfort especially when it bulges through the anatomical defect in the abdominal wall and that is all. Having a thorough hernia examination involving the insertion of fingers by a doctor into the inguinal defect is known to cause pain but it is very unusual that this pain lasts more than an hour or so after the examination.

The hernia itself would not have physically prevented Mr Blue from kneeling or bending down, for example to reach into a safe, but the pain he describes would have understandably made him reluctant to try to do it.

## 3.04 Carpal tunnel syndrome

(a) Documentary evidence from Medical Records

Mr Blue had bilateral carpal tunnel syndrome diagnosed by Consultant Orthopaedic Surgeon, Mr Brown on the 7th June 2010. In correspondence, Mr Ellahee advised that Mr Blue had been suffering numbness of the thumb and first 2 fingers on both hands for at least six years prior to the consultation. The carpal tunnels syndrome was confirmed on electrical neuro-physiological testing and Mr Blue went on to have the left side successfully operated on in July 2010. He is still waiting to have the right side operated on.

(b) Mr Blue's recollection of his symptoms in December 2009

Mr Blue had bilateral hand symptoms with some numbness and tingling making writing and other fine movements for example operating the combination of a lock difficult but not impossible. He is right handed. In December 2009 Mr Blue was frequently wearing support braces on both wrists which provide support and some restriction to movement. He admits he did not wear them all the time.

(c) My examination findings on 14th February 2011

Mr Blue continues to use a support brace on his right wrist and he has a scar on the palmar aspect of his left hand in keeping with previous carpal tunnel surgery.

(d) Relevance to the allegations in this case

The combination of osteoarthritis in the hands and numbness from carpal tunnel syndrome would have made operating a combination safe lock difficult but not impossible.

## 4 Statement of compliance

(a) I understand that my overriding duty is to assist the Court in matters within my expertise, and that this duty overrides any obligation to those instructing their Clients or me. I confirm I have complied with that duty and will continue to do so, I am aware of the requirements set out in Part 35 of the Civil Procedure Rules and the accompanying Practice Direction, the Protocol for the Instructions of Experts to give Evidence in Civil Claims, and the Practice Direction for Pre-action conduct. I am also aware of my obligations under part 33 of the Criminal Procedure Rules. I have obtained the Bond Solon Civil Procedure Rules for Expert Witnesses Certificate to evidence my understanding and compliance with the above requirements.

(b) I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

(c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed.

(d) I consider that all the matters on which I have expressed an opinion lie within my field of expertise.

(e) I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.

(f) In preparing and presenting this report I am not aware of any conflict of interest actual or potential save as expressly disclosed in this report.

(g) In respect of matters referred to which are not within my personal knowledge, I have indicated the source of such information.

(h) I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

(i) Where, in my view, there is a range of reasonable opinion relevant to the opinions I express, I have indicated the extent of the range in the report.

(j) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any alteration, correction, or qualification.

(k) I understand that this report will be the evidence that I will give, if required, under oath, subject to any correction or qualification I may make before swearing to its veracity.

(l) I have attached to this report a statement setting out the substance of all the facts and instructions given to me, which are material to the opinions expressed in this report or upon which those opinions are based.

## 5 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 matter to which they refer.

Signed by Dr Alastair Bint

MBChB DGM DFSRH DRCOG FRCGP MEWI PGCert

Dated

**Appendix 1**

**Consulting room:** St.Lukes Surgery,
Warren Road, Guildford,
GU1 3JH.

**My experience and qualifications:**

I am a full time NHS GP in a practice with a 10,000 patient population and I am a trainer of foundation doctors in General Practice. I am Chairman of the South West Thames faculty of the Royal College of General Practitioners and I sat on the executive committee for General Practice postgraduate training for Kent, Surrey and Sussex Deanery for 8 years. I work as a clinical lead and have sat on the Guildford Practice Based Commissioning board, one of the roles of which is appraising clinical pathways and protocols. I currently sit on the joint GP revalidation board supporting GPs through the educational requirements of the revalidation process and I am a commentator for the Royal College of GPs on professional regulatory and medico-legal issues.

With reference to this case. I regularly perform disability assessments for incapacity benefit, social security, disability tribunals, fitness for Court, employment medicals, DVLA, private companies, public vehicle license, heavy goods vehicle license, amongst others.

**Qualifications:**

- MBChB, Bachelor of Medicine and Bachelor of Surgery, Edinburgh, 1998
- Advanced life support; ACLS (1999), ATLS (2000), PALS and APLS (2001).
- DGM, Diploma in Geriatric Medicine, Royal College of Physicians, 2001
- DRCOG, Diploma from Royal College of Obstetricians and Gynaecologists, 2002.
- DFSRH, Diploma from Faculty of Sexual and Reproductive Healthcare, 2002
- FRCGP, Membership of Royal College of General Practitioners, 2003, Fellowship elected 2009.
- MEWI, Membership of Expert Witness Institute 2008.
- PGCert, Postgraduate Certificate in Diabetes Care; Warwick, 2010

**Memberships:**

- General Medical Council number 4546883
- Medical Defence Union number 307265G
- Royal College of General Practitioners number 53602
- Faculty of Sexual and Reproductive Healthcare number D015276
- Expert Witness Institute number 1776