

Mr N V Todd MD FRCS
Consultant Neurosurgeon & Spinal Surgeon

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Our ref: NVT/SD/30585

Tuesday 18 July 2006

Dear Ms Fitzmaurice

Re: Robert Hamill Inquiry

Introduction

Thank you for passing on to me the medical report of Dr Lawler (Consultant Forensic Pathologist and Home Office Pathologist) dated 23.11.04 and the report of Dr Reid (Consultant Neuropathologist) dated 21.05.05.

Review Medical Report of Dr Lawler

Dr Lawler's conclusions are that there was:

"an unequivocal and incontrovertible direct cause and effect relationship between the assault on 27.04.97 and the deceased's death on 08.05.97.

I believe that the sequence of events can be summarised as follows:-

- *Assault causing significant and permanent traumatic diffuse axonal injury and temporary unconsciousness; this necessitated*
- *Admission to hospital where treatment included*
- *Administration of chlorpromazine... This caused*
- *Development of the neuroleptic malignant syndrome. This is a well recognized but very rare complication of treatment with chlorpromazine and other similar drugs. This then caused*
- *Death".*



I do not consider myself expert in the diagnosis of the neuroleptic malignant syndrome. My general understanding is that Dr Lawler's list of major findings in the neuroleptic malignant syndrome are correct.

Dr Lawler also comments that he would be unable to distinguish the neurological features that were a consequence of neuroleptic malignant syndrome and those that were attributable to the primary brain injury. I agree with that. We know that Mr Hamill had a grade 3 diffuse axonal injury which involved the brain stem. Such brain stem damage could be associated with marked fever (probable hypothalamic damage), with autonomic problems (brain stem injury) and rigidity (for example the arching of the back noted on 01.05.97).

I would not have expected the creatinine kinase (CK) to be elevated as a consequence of the primary head injury. If there had been a great deal of opisthotonus or extensive posturing it is possible that the CK might be raised but there is no evidence from the medical records that that sort of severe posturing was a feature.

However what I can say with complete confidence is that that use of chlorpromazine in a head injured patient who is agitated and restless is entirely reasonable. The neurosurgeons cannot be faulted for using chlorpromazine under these circumstances and of course it will be recognized that the development of the neuroleptic malignant syndrome is rare.

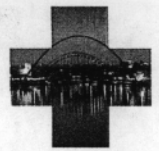
Review Medical Report of Dr Reid

Dr Reid concludes that there was a grade 2 diffuse axonal injury.

Dr Reid concludes that the grade 2 diffuse axonal injury is probably not the cause of death, rather does she think that the probability is that death was caused by a neuroleptic malignant syndrome.

It is noteworthy that Dr Reid's review of the histological slides suggests that there is no major abnormality in the brain stem which would support the idea that the neurological features seen prior to his death was a consequence of a neuroleptic syndrome rather than a consequence of severe brain stem injury.

Dr Reid includes for emphasis that there is no major evidence for hypoxic ischaemic injury and if there was hypoxic ischaemic injury it was not a major or significant cause of Mr Hamill's death.



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Further Opinion

In my report I accepted Professor Crane's view that Mr Hamill suffered a severe grade 3 diffuse axonal injury. Dr Reid believes that the diffuse axonal injury was less severe, grade 2. This weakens my suggestion that Mr Hamill suffered a prolonged and violent assault rather than a single blow to the head and it supports my view that it is not beyond reasonable doubt that he suffered a less severe primary injury causing grade 2 axonal injury. I remain of the view that Mr Hamill's head injury was at a level of violence considerably greater than the average "Saturday night punch-up". As you will have noted from my supplementary report it is simply now possible to be certain as to what level of head injury Mr Hamill suffered even if there was a grade 3 diffuse axonal injury and still less where the diffuse axonal injury is not considered to be grade 2.

I do hope that brings us up to date.

With kindest regards.

Yours sincerely

Mr N V Todd MD FRCS
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