Serious Law LLP
The Guide to Spinal Injury
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About this guide

This guide is designed to offer support and assistance to all those who have been affected by spinal cord injury. This includes the injured person, their family, friends and loved ones.

It contains information on a broad spectrum of topics related to spinal injury, including the following:

- About the spine and spinal cord
- Types of spinal cord injury
- Effects of spinal cord injury
- Rehabilitation for spinal injury
- Available therapies
- Care and assistance
- Financial issues
- Employment implications
- Workplace discrimination
- Housing concerns
- Technology and adaptations
- Mobility and travel
What is the spine?

The spine is an extremely complex structure made up of many constituent parts:

The spinal column

The spinal column is made up of thirty three vertebrae. They are divided into five separate regions, each with a different specific function. These regions are:

<table>
<thead>
<tr>
<th>Region</th>
<th>Description</th>
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<tbody>
<tr>
<td>Cervical (neck)</td>
<td>Seven vertebrae, which in descending order are named C1 to C7</td>
</tr>
<tr>
<td>Thoracic (upper to mid back)</td>
<td>Twelve vertebrae, T1 to T12</td>
</tr>
<tr>
<td>Lumbar (lower back)</td>
<td>Five vertebrae, L1 to L5</td>
</tr>
<tr>
<td>Sacrum (pelvis area)</td>
<td>Five fused vertebrae, S1 to S5</td>
</tr>
<tr>
<td>Coccyx (tailbone)</td>
<td>The four fused vertebrae of the tailbone</td>
</tr>
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</table>

Only the top twenty four vertebrae can move, with the fused bones of the bottom two regions providing structural support.
The functions of the five regions are as follows:

**Cervical**

The cervical spine, or the neck, supports the full weight of the skull and has the greatest range of movement.

Essential to this flexibility are the specialist roles played by the top two vertebrae, known as the atlas (C1) and the axis (C2) respectively. Shaped unlike any of the other vertebrae, the two bones are pivots: the atlas connects to the skull and allows up and down nodding movements whilst the axis enables a side-to-side shaking of the head motion.

**Thoracic**

Contrasting with the cervical region, the twelve bones of the thoracic region of the spine have very limited movement.

With larger vertebrae than those in the neck, the main function of the thoracic region is to connect to the ribcage, which in turn protects the internal organs.

**Lumbar**

The vertebrae in the lumbar region of the spine are larger, wider and broader than those in the two regions above it. It is tremendously strong, carries most of the body’s weight, and absorbs the stress from weight-bearing (lifting and carrying).

There is a greater range of motion possible in the lumbar region than there is in the thoracic region, although not as much as in the cervical region.

**Sacrum**

Immediately beneath the twenty four individual vertebrae, there are the five fused bones of the sacrum. This is a triangular shaped ‘bone’ situated behind the pelvis. Its purpose is to connect the spine to the hip bones (known as the iliac).

**Coccyx**

The final part of the spine is the coccyx – four fused bones often referred to as the tailbone. This is an important attachment for various ligaments and tendons throughout the pelvic area.
The spinal cord

The spinal cord is a slim, white, cylindrical cord consisting of millions of nerve fibres, and is approximately the diameter of a human finger. It begins immediately below the brain stem and on average, descends 43cm to the first lumbar vertebrae (L1). The spinal cord is surrounded by a protective liquid called cerebrospinal fluid (CSF), which acts as a buffer to protect it from damage.

The spinal cord only makes up a small part of the central nervous system (a mere 2%), but it carries out two very important functions:

1. Connects a large part of the nervous system to the brain. Nerve impulses are transmitted to the spinal cord through sensory neurons and then sent by the spinal cord to the brain. In the reverse process, impulses are generated in the brain, transmitted down the cord and out to the muscles via motor neurons.

2. Acts as a co-ordinating centre for the simple reflexes that we perform instinctively. Such examples include the withdrawal reflex, where the automatic response to touching something hot is to draw our hand away quickly, or the patellar reflex most commonly tested by medical professionals and GPs.

Thirty one pairs of spinal nerves, also known as nerve roots, branch off from the spinal cord. They pass through holes in the vertebrae and branch out to control all the different parts of the body as part of the peripheral nervous system. Nerves relaying information from the brain to the body are called motor neurons, and nerves carrying information from the body to the brain are known as sensory neurons.
Nerves along the spinal cord control distinct bodily functions, depending on their location along the spinal column:

Cervical Nerves

Although there are only seven vertebrae in the neck, there are eight pairs of spinal nerves numbered C1 to C8. These enable breathing, and provide movement and feeling to the head, neck, shoulders, arms and hands.

Thoracic Nerves

Twelve pairs of spinal nerves (T1 to T12) in the upper back, which connect and control muscles in the back, chest and upper abdomen.

Lumbar Nerves

Five pairs of spinal nerves (L1 to L5) that control the lower back and regions of the thighs and legs.

Sacral Nerves

Five pairs of spinal nerves (S1 to S5) that control the buttocks, the bladder, bowel, sexual function and most of the legs and feet.

The five main parts of the spinal cord are:

1. **White Matter** – Contains the axons of the spinal cord
2. **Spinal Nerve** – Carries nerve impulses
3. **Central Canal** – Fluid-filled space running the length of the spinal cord
4. **Grey Matter** – Contains nerve cell bodies
5. **Dorsal Root Ganglion** – Receives impulses from other areas such as the skin for transmission to the brain
Types of spinal injury

Spinal shock

Typically, the full extent of an injury is not known until 6 - 8 weeks post injury. This is because within minutes of an injury occurring, something known as ‘spinal shock’ can take place. During spinal shock, the nervous system is unable to transmit signals, and some of this ability may return once the spinal shock has subsided.

Despite no two spinal cord injuries being exactly the same, they are described as either an incomplete or a complete spinal cord injury.

Incomplete spinal cord injury

If the spinal cord has only been partially damaged, it is described as an ‘incomplete spinal cord injury.’ With an incomplete injury, it is possible that some motor and sensory function may remain below the level of the injury. However, the effects vary from patient to patient. For example, some patients may retain feeling but have little or no movement, whereas other patients may retain movement but have no feeling.

Complete spinal cord injury

A complete spinal cord injury occurs when there is a loss of function below the site of injury. The brain is no longer able to send signals down the spinal cord past the lesion line and depending on which part of the spinal cord is damaged, the resulting injury will be either complete paraplegia or complete tetraplegia/quadriplegia.
Paraplegia

Complete or incomplete paraplegia can arise when a spinal injury occurs below the neck. Damage to the following regions of the spine can result in paraplegia:

- Thoracic (T1 to T12) – the upper middle region.
- Lumbar (L1 to L5) – the lower middle region.
- Sacral (S1 to S5) – the lower region.

The degree of paralysis for complete paraplegia varies, and it depends on the site of injury on the spinal cord. Whilst use of the arms and hands is retained in paraplegia, its effects may range from impaired leg movement to total paralysis of the legs and trunk up to chest level.

Tetraplegia / quadriplegia

Tetraplegia (sometimes called quadriplegia) occurs when a significant injury is sustained to the neck – the cervical region of the spine. It can result in complete or incomplete paralysis of the arms, legs and body.

Cauda equina syndrome

This refers to a compression of the nerves that are located between the L1 and L2 vertebrae. Injury will cause partial or complete loss of movement and sensation. It is possible, if the nerves are not too badly damaged, for them to grow again and for a functional recovery to be achieved.
Effects of spinal injury

Incomplete spinal injury

There are four classifications of incomplete spinal injury:

**Anterior cord syndrome**

Damage will have occurred towards the front of the spinal cord. The effect on the patient can be a total or a reduced ability to sense pain, temperature and touch sensations below the level of their injury.

**Central cord syndrome**

Damage will have occurred in the centre of the spinal cord. This can result in the loss of function in the arms but some leg movement may be preserved. Preservation of control over the bowel and bladder may also be possible.

**Posterior cord syndrome**

Damage will have occurred towards the back of the spinal cord. The patient may retain muscle power, pain and temperature sensation. However, they may experience difficulty in coordinating movement of their limbs.

**Brown-Sequard syndrome**

Damage will have occurred towards one side of the spinal cord. This causes an impaired or loss of movement to the injured side, but pain and temperature sensation may be preserved. The side that is not injured will have normal movement, but pain and temperature sensation will be impaired or lost.
Paraplegia

The following tables indicate the likely effects of the different levels of paraplegia. They are a general guide only – the impact of spinal injury will vary from person to person.

**Universal effects (injury anywhere in the thoracic region and below)**
- Full head and neck movement, with normal muscle strength
- Normal shoulder movement and normal use of arms, wrists and fingers
- Loss of bladder and bowel function

**Location-specific effects**

<table>
<thead>
<tr>
<th>Level of injury</th>
<th>Possible Effects</th>
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</thead>
</table>
| T1 - T12        | Paralysis of lower body and legs.  
|                 | Varying abdominal strength / upper-body strength. The lower the injury, the greater the strength. This affects the ability to balance while sitting.  
|                 | Inability for a man to achieve erection or ejaculation. |
| L1 - L5         | Normal upper-body strength.  
|                 | May possess ability to have psychogenic (thought controlled) erections. |
| S1 - S5         | Normal upper-body strength.  
|                 | May possess ability to have psychogenic (thought controlled) erections.  
|                 | Depending on the level of injury, may possess very limited ability to control extension / flexion of the hip, thighs, knees and toes. |

**Aftermath**

Injuries causing paraplegia usually require a stay in a specialist spinal hospital for several months. During this time, extensive rehabilitation, skill-building and physiotherapy is undertaken. Upon discharge, people with paraplegia can usually remain fully independent with the ability to provide full self-care. A self-propelled wheelchair may be used for mobility, but some people may be able to stand and walk for short periods of time using aids and assistance.
**Tetraplegia**

Complete tetraplegia is the most severe and debilitating type of spinal injury. It is the loss of function and sensation in the arms, legs and body caused by complete damage to the spinal cord in the neck (cervical region).

The following table indicates the potential outcome of the different levels of injury. Again, this is a general guide only – the impact of spinal injury will vary from person to person.

**Universal effects (anywhere on the cervical region)**
- Complete paralysis of the body and legs
- Loss of sexual function
- Loss of bladder and bowel control

**Location-specific effects**

<table>
<thead>
<tr>
<th>Level of injury</th>
<th>Possible Effects</th>
</tr>
</thead>
</table>
| C1 & C2        | Inability to breathe unaided (mechanical ventilation may be required).  
Inability to move the head and neck.  
Build-up of waste in wind-pipe – assistance required to initiate coughing. |
| C3             | In most cases, able to breathe unaided.  
Inability to move the head and neck.  
Build-up of waste in wind-pipe – assistance required to initiate coughing. |
| C4             | May possess limited arm function.  
Limited ability to move the head and neck (fully able in some cases).  
Limited ability to move shoulders.  
Build-up of waste in wind-pipe – assistance required to initiate coughing. |
<table>
<thead>
<tr>
<th>Level of injury</th>
<th>Possible Effects</th>
</tr>
</thead>
</table>
| C5             | May possess limited arm function.  
                | Fully able to move head and neck with good muscle strength.  
                | Able to move shoulders and bend elbows.  
                | Build-up of waste in wind-pipe – assistance required to initiate coughing. |
| C6             | May possess limited arm function.  
                | Fully able to move head and neck with good muscle strength.  
                | Able to move shoulders and bend elbows.  
                | Able to lift hands (wrist extension).  
                | Build-up of waste in wind-pipe – able to cough unaided in most cases. |
| C7 & C8        | May possess limited arm function.  
                | Fully able to move head and neck with good muscle strength.  
                | Able to move shoulders and bend elbows.  
                | Able to lift hands (wrist extension).  
                | Partial finger movement, grip and mobility.  
                | Potentially able to self-transfer in and out of wheelchair.  
                | Build-up of waste in wind-pipe – able to cough unaided in most cases. |

**Aftermath**

A high level of care and assistance is required after a serious spinal cord injury of this nature. Usually, a prolonged stay in a specialist spinal hospital is required for rest and rehabilitation. Following discharge from the hospital, the use of technology combined with appropriate care and assistance can help the injured person to live as full a life as possible. Examples of the ever-improving technology include voice-controlled domestic temperature and lighting regulation devices.
Secondary effects

In addition to the primary effects of spinal injury, some of the most common secondary effects are:

**Nerve pain**

When the fibrous nerves of the spinal cord become partially damaged, the change in structure of the cord itself can cause chronic levels of pain and discomfort. Although it is not yet fully understood why this occurs, it is believed that the surviving nerve fibres become over-stimulated to compensate for the dead fibres, triggering painful activity throughout the nervous system.

**Pneumonia**

A loss of muscle control in spinally injured people increases the risk of infection of the respiratory system, and pneumonia in particular. Pneumonia is an infection of the lungs which is potentially lethal if untreated. Its symptoms include difficulty breathing, coughing, chest pains and fever. Respiratory exercises and good posture may help spinally injured individuals minimise its risk.

**Pressure sores**

With limited mobility, low levels of sensation and reduced blood flow, spinally injured people are highly susceptible to pressure sores (also referred to as bed sores). Ulcers can form if the individual does not move regularly as the skin and tissue is unable to withstand extended periods of sustained pressure.

**Muscle spasticity**

Spasticity is an exaggeration of the normal reflexes that occur when the body is stimulated in certain ways. When nerves below an injury become disconnected from those above, these responses become exaggerated. Spasms occur when these nerves are stimulated, particularly when the associated muscles are stretched.
<table>
<thead>
<tr>
<th><strong>Autonomic dysreflexia</strong></th>
<th><strong>Bladder management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This condition can be extremely dangerous and is potentially life-threatening. A complete spinal cord injury prevents the brain from sending and receiving messages below the site of injury, inhibiting its ability to regulate blood pressure and dilate or contract the blood vessels around the body.</td>
<td>After a spinal cord injury, impulses may no longer travel normally between the bladder and the brain. Individuals may no longer be able to sense when their bladder is full. If this is the case, bladder management will usually be undertaken by the process of catheterisation.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Temperature regulation</strong></th>
<th><strong>Hyper / hypothermia</strong></th>
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<tbody>
<tr>
<td>Spinal cord injury can affect two of the processes required for temperature regulation – namely, sweating and shivering. As a result, those who have suffered a spinal cord injury must carefully manage the temperature of their environment to prevent their body temperature rising or falling beyond normal levels.</td>
<td>Hyperthermia refers to increased body temperature, whilst hypothermia refers to decreased body temperature. Both are potentially very dangerous. Symptoms of hyperthermia include hot, dry skin and nausea. Hypothermia may cause low body temperature and violent shivering.</td>
</tr>
</tbody>
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<thead>
<tr>
<th><strong>Bowel management</strong></th>
<th><strong>Cardiovascular disease</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>As with bladder management, the impulses between the bowel and the brain may no longer function normally. In this situation, a planned management routine is implemented to avoid a reduction in independence.</td>
<td>Due to the reduced function in a spinally injured person, there is an increased risk of cardiovascular disease and other cardiovascular concerns such as deep vein thrombosis (DVT) and coronary heart disease (CHD).</td>
</tr>
</tbody>
</table>
Rehabilitation

With spinal injury, early medical and therapeutic intervention is crucial to maximise the injured person’s recovery and a suitable rehabilitation programme is essential. It can be a long process, and at times it may be challenging, but with the right rehabilitation package, advances may be made.

The nuances of spinal injury mean that rehabilitation programmes must be customised on a case-by-case basis in order to match the particular circumstances of each patient.

A productive rehabilitation programme should be a team effort, where the injured person is a key part of the team as well as the medical staff. Everybody must work together in order to tackle the challenges involved in improving the patient’s day-to-day quality of life. Some of the medical staff that will typically be involved include (but are not limited to) the following:

- Physiatrist (usually leading the rehabilitation programme) / spinal consultant
- Social workers
- Physical and occupational therapists
- Recreational therapists
- Rehabilitation nurses
- Nutritionists

The stages of rehabilitation

Stage 1  Acute rehabilitation

This refers to the short-term treatment administered in hospital immediately after the spinal injury. It begins as soon as medical attention can be paid to the spinal cord.

If necessary, the spine will be immobilised and realigned in order to prevent any further injury. If required, respiratory assistance can be provided.

Depending on the extent of the injury suffered, there may be a period spent in an intensive care unit, but once this has concluded, the patient will usually be transferred to a specialised spinal hospital / unit.
Where possible, a steroid called methylprednisolone may be administered in order to reduce damage to spinal nerve cells and to decrease the inflammation around the cord (to reduce any ‘spinal shock’). This makes it easier for medical specialists to:

- Complete a full neurological assessment
- Diagnose the severity of the injury
- Predict the likely extent of achievable recovery

**Stage 2 Inpatient rehabilitation**

Once the exact nature of the spinal injury has been determined, the various intensive therapies that are conducted in the hospital can begin via the inpatient rehabilitation phase.

The injured person will be helped to adapt to their new circumstances, and they will re-learn how to perform day-to-day tasks. This phase is designed to advance the patient’s rehabilitation to a point where they have regained enough independence to be able to return home.

There will be an initial focus on improving basic function and strength because both must be addressed as soon as possible in order to minimise any secondary complications.

As basic function and strength improve, the rehabilitation team will address the wider range of issues such as mobility, bowel and bladder training, diet and nutrition, exercise, sexual function and general daily living. Close family members are often encouraged to participate in some of these therapies in order that they can understand and become familiar with their loved one’s needs and help to prepare for life outside the hospital.
Stage 3  Outpatient rehabilitation

Once a patient has shown sufficient improvement, they can be discharged from hospital and continue their rehabilitation either at home, in a rehabilitation centre, or at a combination of the two.

The aim of this stage is to continue to improve a patient’s condition to help them achieve the maximum possible level of independence.

The number of sessions required will depend on the patient’s personal situation. Some may require weekly sessions, some daily, and others may need several different therapies each day.

Types of therapy

Rehabilitation of a spinal cord injury will require a range of different therapies. This section takes a look at some of the more common types:

Physical therapy

The aim of physical therapy is to strengthen a patient’s muscle groups and improve their general motor skills. For example, those who have suffered a high level spinal injury may need to strengthen their ability to breath unassisted or to develop coughing techniques to clear the windpipe. Specific muscle groups control these functions, and they may need to be strengthened in order to operate effectively.

The exact nature of a physical therapy programme will depend upon the level of the spinal cord injury and the individual needs of each patient.

Some examples of physical therapy include:

- Training to improve mobility
- Re-training bowel and bladder management
- Coping strategies for spasms, autonomic dysreflexia, chronic aches, pins and needles etc.
Occupational therapy

Occupational therapists teach the skills necessary to achieve as high a level of independence as possible. Examples include self-grooming, dressing, feeding, co-ordination, and how to use adaptive equipment.

Psychological therapy

After a spinal cord injury, people are understandably susceptible to depression. Psychological therapy provides emotional support for both the patient and their family as they come to terms with what can be life-changing injuries.

Vocational rehabilitation

Vocational rehabilitation assesses whether the patient’s mental and physical abilities are strong enough for them to return to the workplace. If so, the specialist will assist with finding work and also help to make any required adaptations to the workplace.

Recreational therapy

For those unable to return to work (or alongside a return to work), recreational therapy programs can provide athletic pursuits that aim to encourage an active body and mind whilst also providing opportunities for social interaction.

Social workers

Social workers will also be involved to assist the patient and family by planning and implementing strategies to cater for future needs. Examples include arranging for assistive equipment, identifying local community resources and considering the need for and frequency of home visits.
History of treatment

Modern medicine has made great advancements in treating spinal cord injury, and this section discusses its progression from World War II through to its potential future developments.

1939 onwards: New methods

Prior to World War II, spinal cord injuries almost always resulted in death, usually caused by urinary tract infections and pressure sores. Paradoxically, the onset of the most devastating war in history was the catalyst for the increased chance of survival after spinal cord injury.

British consultant neurologists helped to establish the Emergency Medical Service and twelve specialised spinal hospitals. One was Stoke Mandeville, and from 1944 its director was Ludwig Guttmann (1899-1980); a Jewish clinical neurologist who had escaped persecution in Germany, and was to become the father of modern spinal cord injury treatment.

Guttmann was the first to unify several previously established spinal injury principles. With a benevolently dictatorial style, he demanded regular bi-hourly turning of patients to eliminate pressure sores and he implemented urinary tract catheterisation (though some staff and patients were initially resistant to his new methods). Ultimately, Guttmann successfully reduced fatalities.

After his studies on peripheral nerves, Guttmann’s ideas on physiology, neurosurgery and rehabilitation enforced his conviction that a complete spinal injury treatment system was required; consisting of specialised spinal units; immediate specialist treatment; after care; immediate and ongoing patient supervision; detailed documentation; mental wellbeing; rehabilitation and exercise (he began the Stoke Mandeville games in 1948, later becoming the Paralympic Games). Guttmann’s integrated methods are now the worldwide standard.

Present day: Improved treatment

Since Guttmann’s standardisation of spinal cord injury treatment, a host of ever-improving technologies, medication and practices have been developed. MRI scanning has played a vital role in assessing the extent of damage sustained whilst the introduction of anticonvulsant and antidepressant medications have been beneficial in suppressing or relieving some post-injury pain.
Similarly, vast and rapid clinical advances have made surgery much safer. Equipment such as the surgical microscope has been introduced and the spinal column may now be approached from any angle to allow bone fusion and stabilisation. Treatment for bladder, bowel, skin and spasticity management have all improved considerably whilst rehabilitation services and lightweight aids are now more freely available.

Notably, there is more robust legislation in place for people with spinal cord injuries, and for those with disabilities in general. Public places are now more accessible and under the Equality Act 2010 and UN Convention, governmental disability rights extend to employment, education and police matters. As a result of such improved treatment and socio-economic factors, life-expectancy after a spinal cord injury has increased and continues to do so; something almost unthinkable just decades previously.

**The future: Potential cure**

Recent decades have seen increased focus on finding a cure for spinal cord injury. The complexity of the spinal cord and central nervous system requires research into several areas at once, with particular attention paid to reducing injury damage; creating ‘nerve bridges’; reducing scarring; replacing lost cells; and reducing neuro-circuit deficits.

There has been huge investigation into the field of spinal cord regeneration, and one of the most well-known methods of this (and one that has shown very promising results) is in stem cell research. Stem cells are able to divide and bring forth nearly all the types of cells within the human body, and though in some quarters the research is considered controversial, breakthroughs in nerve cell and fibre regrowth have been confirmed by Harvard Medical School, the University of California and King’s College London.

The three main findings are: that it is possible to grow nerve fibres back into the spinal cord; the nerve fibres are able to reconnect with nerve cells; the ability to feel can be regained. With science, technology and our understanding of spinal cord injury developing at its fastest rate in human history, faith in finding a future cure for spinal cord injury may not be misplaced.
Common areas of concern

The initial period after a spinal injury can be a time of fear and bewilderment for all concerned. It may even be unclear if the injured person will survive. Certainly the extent of the injuries, or how they will impact on daily life in the long-term, will be unknown. During this period, it is important to take one day at a time, trusting the health professionals and focusing on each small improvement.

As the situation becomes clearer, it will be possible to start considering the available options. There are a wide range of organisations, services and specialised products carefully designed to allow those with spinal injury to achieve as much independence as is possible for their circumstances.

Some common concerns which arise from a serious injury, and examples of potential solutions, are as follows:

Mobility and travel

Mobile independence

Getting around is of paramount importance to most people’s day to day lives. Having this ability restricted is often one of the first and most obvious concerns for those with spinal injury.

Regaining even a small amount of mobile independence can represent a very important step on the road to recovery.

Mobility specialists

The process of assessing new mobility needs will depend on each person’s individual circumstances. A mobility specialist can offer advice and will consider feedback and concerns.

There is a large range of products designed to help injured people with their mobility needs. With the right assistance, a process can be undertaken in order to find the best solution for each individual.
Employment implications

Employer responsibilities

Employers have a legal responsibility not to discriminate against their employees due to any disability. They are required to consider making ‘reasonable adjustments’ to an injured person’s working situation in order to allow a return to work. Businesses differ in size, structure and resources, so it is important to appreciate that ‘reasonable adjustments’ is a relative term.

Examples of such ‘reasonable adjustments’ include the following:

- A phased return to working hours
- Time off for medical treatment
- Providing practical aids and equipment
- Moving to another suitable role within the business

If the injured person is still unable to carry out their job, even if ‘reasonable adjustments’ are made, then an employer may be within their rights to dismiss them, providing they give proper notice.

Discrimination

Employers have a legal responsibility not to discriminate against their employees. They must not put their employee under pressure to resign, or unfairly choose them for redundancy because of their new circumstances.

A simple guideline is that the injured employee must not be treated less favourably than other employees because of something connected to an injury.
Statutory Sick Pay (SSP)

If a spinally injured person is unable to work, they may be entitled to Statutory Sick Pay or their company’s own sick pay scheme. Any such scheme should be equal to, or better than, the statutory minimum.

If they are still unable to work after 28 weeks and are not entitled to Statutory Sick Pay, they may be entitled to Employment and Support Benefit Allowance – see the Benefits section on page 24.

Future employment prospects

If the injured person is unable to continue their current job, they may need to start planning for future employment by undergoing new occupational training. There are many different ways to do this, ranging from conventional education to more specialist retraining. Some charities provide retraining for those who cannot take the conventional education route. For further information, see the Useful websites and organisations section on page 26.

Housing concerns

After a spinal injury, the injured person’s previous living environment may no longer be suitable. Issues such as the height of the kitchen surfaces or the position of light switches can suddenly become important.

Subject to available funding, specialist architects and housing adaptation professionals can provide bespoke solutions in these circumstances. For example, special fittings can be installed to allow kitchen surfaces to be raised and lowered. Modern day technology can be utilised to provide assistance with even the most difficult of circumstances.
Financial issues

It can be very stressful when considering how to cover any new financial burdens whilst also meeting any existing commitments. If a spinal injury creates an inability to work, a household income can be significantly reduced and the specialist care, support and equipment that may be needed can also be very expensive.

There are several forms of financial support that may be available to help.

Benefits

Certain government funded benefits schemes exist to help support those who suffer a serious injury. The amount of financial support available depends on individual circumstances and also on the political and administrative policies at the time.

The Department for Work and Pensions is the branch of the government that is responsible for distributing benefits. To explore their current benefits policies, visit www.gov.uk/dwp.

Community care services

Community care services (sometimes referred to as statutory services) are provided by the local authority for people who have difficulties managing their daily activities and in particular, those who have “a substantial and permanent disability”. The local authority has a legal duty to provide an assessment for any person who may require community care services, and once the need for this has been established, it also has a legal obligation to provide the services.

This may include the provision of a home carer or personal assistant; respite services; day care or nightsitting services; or the provision of care within a care home. It may also entail the provision of aids, appliances and adaptations in the home; the delivering of pre-prepared meals; welfare and benefits advice; the provision of transport services; or any rehabilitation requirements.
Legal compensation

There may be a legal case for a spinally injured person to pursue compensation in order to help deal with their new financial requirements, and it is recommended that this possibility should always be explored after a serious injury.

Initially, some may not believe that they have grounds for a case, but legal issues can be extremely complicated, so professional advice based upon a consideration of all the relevant circumstances should be sought.

Therefore, it is important to choose a law firm that has a proven track record and the necessary expertise to act successfully in highly complex spinal injury cases, often involving multi-million pound settlements.

This guide has been produced by Serious Law LLP, a leading UK specialist law firm dealing exclusively with very serious and catastrophic injury cases on a nationwide basis.

Please visit their website [www.seriousinjurylaw.co.uk](http://www.seriousinjurylaw.co.uk) or telephone **0800 61 66 81** for further information and details of their free consultation service.
Useful websites & organisations

We have compiled a list of some useful websites and organisations for offering advice and assistance for those affected by spinal injury.

**Serious Law LLP** is a leading UK law firm dealing exclusively with serious and catastrophic injury cases on a nationwide basis. They are dedicated to helping spinally injured people rebuild their lives by providing ongoing expert support and assistance.

**Back Up** is dedicated to providing guidance, support and training courses for those who are affected by spinal injury. Their mission is to deliver inspirational services that build the confidence of the spinally injured, helping them to realise their full potential.

**Spinal Research** is one of the UK’s largest spinal charities, and is committed to raising funds for groundbreaking spinal injury medical research. It is hoped that this will help the development of reliable neck, back and spinal cord injury treatments.

The **Rooprai Spinal Trust** is a completely volunteer-led charity dedicated to helping people affected by spinal injury. The charity’s mission is to fund research into paralysis and make physiotherapy available for all who have experienced a devastating spinal cord injury.

The **Spinal Injury Network** is an information and forum-based website. The site’s owner suffered from a severe spinal cord injury, and began the site to provide an online community where spinally injured people can offer each other support.
This guide offers information about the spine, the types and effects of spinal injury, and other associated issues such as rehabilitation and future implications.