specialistopinion
GROUP

Dr John Bosanquet
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31 May 2022

Our Ref: 60003581

CONFIDENTIAL

GIO Workers Compensation (NSW) Ltd
GPO Box 1464
SYDNEY NSW 2001

ATTENTION: Sarah Behne-Smith. WPI Specialist

INDEPENDENT MEDICO-LEGAL REPORT

Dear Sarah Behne-Smith

Re: [redacted]
Claim No: [redacted]
Date of Birth: [redacted]
Date of Injury: 26/06/2017
Address: [redacted]
Employer: Wynstan Blinds
Occupation: Labourer
Date of Examination: 19/05/2022

Thank you for your letter of 09/03/2022 requesting a report on this man. I saw and examined him in Sydney on 19/05/2022. I explained to him the purpose of the visit and that a report would be forwarded to your company.

I acknowledge that I have read the Expert Witness Code of Conduct contained in Schedule 7 of the Uniform Civil Procedures Rules 2005. I agree to be bound by the Code. I also acknowledge that I have read the PIC4 Procedural Directions for Expert Witness Evidence and I agree to be bound by these Directions. To the best of my ability this report has been prepared in accordance with these Directions.

Thank you for the enclosed medical documentation, which comprised reports from Dr Geoffrey Rosenberg, treating Orthopaedic Surgeon, 03/09/2017, 24/09/2017, 27/10/2017, 02/03/2022; Dr Paul Carney, Neurosurgeon, 01/11/2017, 21/11/2017; Dr Andrew Keller, Occupational Physician, 05/12/2017, 06/12/2017; Dr James van Gelder, treating Neurosurgeon, 22102/2022.

[redacted] understood that I could not offer him advice regarding the treatment of his orthopaedic condition.

SOCIAL HISTORY

[redacted] is a 43-year-old man (DOB 01/01/1979). He is married and has three children aged four, seven and 18 months. His wife does not work. The family resides at 7/74 Beaconsfield Street, Silverwater NSW 2128. He is right hand dominant and attended alone.

EMPLOYMENT HISTORY

[redacted] is not working. He last worked in December 2017. He was employed by Wynstan Blinds and had been employed there for four months, having started work with them a month prior to the injury. He was employed as a labourer helping move machinery to another factory. Prior to this he had been a dogman for a month and had also worked m Darwin installing NBN cables for six to eight months. He had also been a process worker in Sydney. He came to Australia from Afghanistan by boat in 2001.

HISTORY OF THE INJURY

While employed by Wynstan Blinds, [redacted] sustained an injury to his low back on 26/06/2017. Trays of fabric were having to be moved and these weighed up to 100kg. Initially there were four men moving each tray, one on each comer but as the day progressed there were only two men and he then developed low back pain. He finished the shift and went home. He had some pain in his legs and difficulty standing. He applied Deep Heat

His symptoms were worse the next morning and he rang his supervisor. He did go to work the following day and was given light duties. He finished early. He saw his local doctor who performed X-rays and an MRI scan and referred him for physiotherapy. He took a month off work. He also saw a specialist and had several cortisone injections. He commenced swimming and going to the gym. The injections gave little relief. The specialist he saw was Dr Geoffrey Rosenberg, an Orthopaedic Spinal Surgeon. He was no better after the injection and went back to work on light duties for three months lifting no more than 5kg. He also avoided prolonged sitting and standing. At this point he was then terminated. He has not worked since that time. He has continued to have physiotherapy and hydrotherapy, the former two days a week. He has been taking Panadeine Forte, one to two a day and is on Norspan patches. He also takes three to four Panadol a day.

He has been reviewed by Dr Geoffrey Rosenberg who has recommended a discectomy and spinal fusion.

CURRENT SYMPTOMS

[redacted] has tow back pain that is constant without any pain free days. It does vary and is worse with prolonged sitting and standing, coughing or sneezing. There is pain in his left leg particularly in the front of the thigh, the medial calf and toes. He has noticed paraesthesia and numbness and "feels no leg".

The leg feels heavy on the left side and there is pain fn his right buttock. He has had some urinary frequency and pain in the left testicle. He has been seeing a psychiatrist on a regular basis.

Domestic

[redacted] lives in a second floor unit with no lift. He is able to drive an automatic vehicle for about 30 minutes. He does help his wife with the shopping but she does alt the cleaning.

Self-Care

He manages to be independent

PAST HISTORY

There has been no other history of a motor vehicle accident nor has he had a back injury.

GENERAL HEALTH

He is a hypertensive on medication. He suffers from asthma. He is depressed and on Aropax.

PAST SURGERY

There is no other history of surgery.

EXAMINATION

This revealed a man whose appearances matched that of NSW Drivers Licence number 14702171. He measured 5'8" and weighed 108kg. He was wearing a lumbosacral support which he removed for the examination. He was able to stand on his heels and toes and perform a minimal squat. He walked with a slight limp.

Lumbar Spine

He was tender over the left sacroitiac region. His forward flexion was such that his hands reached to his knees. Extension was greater than neutral. Rotation to the right caused pain and lateral bending was only 50% to right and left.

Straight leg raise was limited by his tight hamstrings at 60° and then became painful. There was altered sensation throughout the whole of the left leg, thigh, calf and foot in a non-dermatomal fashion. There was no motor deficit and his knee jerks and ankle jerks were very brisk. Both calves measured 44cm.

INVESTIGATIONS

1. **X-ray lumbosacral spine, 02/0712017**
   Degenerative spondylosis is noted within the lumbar spine with endplate osteophytic lipping and narrowing of the intervertebral disc heights posteriorly particularly at L5/S1.

2. **MRI lumbar spine, 12/07/2017**
   Minor disc dehydration at L4/5 and the L3/4 level.

3. **CT guided left L5 nerve root block, 05/09/2017**

OPINION

This 43-year-old man, who has worked as a labourer for Wynstan Blinds for a short period of time, has injured his back during the course of his work on 26/06/2017. He has been found to have a disc lesion at the L4/5 level. His symptoms have been refractory to treatment including a cortisone injection. Surgery has been recommended. He has not been able to return to any form of employment

<u>In answer to your specific questions:</u>

1. **Please provide a brief history of the work injury of 26/06/2017 including your opinion on diagnosis the mechanism of injury, results of any radiology and treatment undertaken to date.**

   Please see report under 'History of Injury', 'Current Symptoms' and 'Investigations'.

2. **In your opinion has a pre-existing injury, condition or abnormality caused or contributed to the impairment resulting from the work related injury. If so, please detail the consequences of the pre-existing condition and how it contributes to the impairment arising from the injury. If the worker did suffer from a pre-existing condition or injury prior to the subject injury please detail the diagnosis and the medical evidence you rely upon in forming your opinion.**

   There has certainly been pre-existing degenerative changes *in* his lumbar spine and these have contributed to the injury to the L4/5 disc.

3. **If the worker did suffer from a pre-existing condition, please advise whether the work injury caused aggravation, exacerbation, deterioration or acceleration of that condition in respect of the subject injury.**

   It is my opinion that [redacted] suffered a pre-existing condition and the work injury aggravated those degenerative changes at L4/5.

4. Has a later or subsequent injury or subsequent exacerbation occurred?

There has been no subsequent injury or exacerbation.

5. Would that injury have occurred had the claimant been in the physical condition caused by the initial injury at the time of the subsequent injury.

Please note there was only one injury.

6. If an exacerbation has occurred subsequent to the original injury, would some part of the subsequent damage have occasioned even if the original injury had not occurred? If so, to what degree is the extent of the continuing permanent impairment of the worker attributable to the first injury?

His ongoing *impairment* is *due* to the first injury.

7. Whether the claimant's capacity for employment is affected by these alleged injuries, and if so, what restrictions would you place on his employment.

His capacity for employment has been affected. He has not worked now for nearty five years. He would be able to work avoiding lifting. more than 5kg, repetitive bending, twisting and turning.

8. Whether the claimant would benefit from any further medical treatment including the cost of same, and whether you could consider the treatment reasonable and necessary.

Surgery has been recommended; however it is my opinion that surgery will not relieve this man's pain nor allow him to return to the workforce. I would recommend:

a) A weight ioss programme
b) A continued core strengthening programme

9. Your opinion as to whether the claimant has reached maximum medical improvement.

The NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th Edition, Page 4, Paragraph 1.15, defines maximum medical improvement It is my opinion using this definition that [redacted] has reached maximum medical improvement.

Whole Person Impairment

10. The claimant is now being assessed for whole person impairment for the application of 539. Please provide your assessment of the claimant's whole person impairment in accordance with the AMA 5 and aforementioned 5IRA Guidelines.

a) Whole person impairment stemming from the injury dated 26/06/2017

I. **Lumbar spine**

With reference to AMA 5. page 384, Table 15-3, he has a DRE lumbar Category II with a 5 to 8% impairment. I have given him a baseline of 5% and added 2% for the restrictions of activities of daily living, giving a 7°/o whole person impairment

b) Do you consider a deduction is appropriate under 5323.1 of the *Workplace Injury Management and Workers Compensation Act 1998* as a result of any previous injury, condition or abnormality. Please justify your response.

t consider a deduction of one-tenth is appropriate due to pre-existing degenerative changes. One-tenth = 0.7 % when deducted, leaves a 6% rounded whole person impairment.

c) If you consider upon examination that AOL modifiers exist due to the workplace injury please provide your opinion on the following:

- **What degree is this behaviour attributable to the impairment claimed as opposed to any domestic arrangement that pre-existed the injury.**

  It is my opinion that the loss of ADls is a result of the injury.

- **Does any impairment for AOL stem from injury to the back or other impairment.**

  It stems from an injury to the lumbar spine.

d) If you believe there is whole person impairment as a result of radiculopathy, could you please justify *your* reasoning referencing the AMA 5 and 51RA N5W Workers Compensation Guidelines for the Evaluation of Permanent Impairment.

Please note there is no evidence of radiculopathy.

In answer to your further five questions:

1. **Do you agree with Dr Rosenberg's assessment regarding the discogram?**

   The discogram does show a ruptured disc at L4/5.

2. **Is the proposed surgery medically appropriate?**

   Spinal fusion has at the very best a 50% chance of improving pain and allowing this man to return to work. It. is my opinion that a surgical fusion wm not diminish his pain or allow him to return to employment. It is my opinion that it is not medically appropriate.

3. **What is the expected outcome of the procedure. What is the likelihood of a significant benefit in terms of symptoms and function?**

   As stated, it is my opinion that the outcome is poor, particularly with his underlying mental health issues.

4. **What are the risks of this procedure.**

   The risks are the standard ones: from the anaesthetic, including death, infection, haematoma, nerve damage, failure of the fusion to unite and ongoing pain.

5. **What other alternative treatment options exist?**

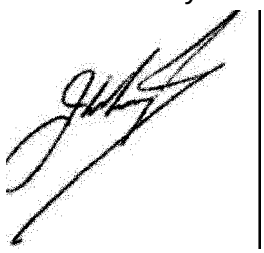
   a. **Please advise if any alternatives are more cost effective and or have a better expected outcome than the proposed surgery?**

      The other treatment option is to continue with a non-operative approach. He should have a weight loss programme and continue with a core strengthening regime. This would certainly be more cost effective.

   b) **Please advise if you would recommend alternative treatment and if so, please detail the type and duration, frequency?**

      I have detailed this above.

Yours faithfully



John Bosanquet

Dr [redacted]

[redacted]

b.ASSESS
Cl 17 MEDICAL GROUP

15 November 2022

Ms Bianca Santoro
Lawyer
Slater & Gordon Lawyers
Ground Floor
6-8 Holden Street
Ashfield NSW 2131

Dear Ms Santoro,

Re		**Mr** [redacted]
Address		[redacted]
Date of Birth		[redacted]
Occupation		**Storeperson/Labourer**
Employer	:	**Wynstans Blinds**
Date of Accident	:	**26 June 2017**
Claim/Ref No	:	[redacted]
Date of Consult	:	**15 November 2022**

I re-examined Mr [redacted] on 15 November 2022 at your request having seen him on two previous occasions, namely 11 October 2018 and 1 November 2021.

CODE OF CONDUCT

I acknowledge that I have read the Expert Witness Code of Conduct contained in the (amended) Schedule 7 of the Uniform Civil Procedures Rules 2005. I agree to be bound by the Code. I also acknowledge that I have read the PIC4 Procedural Directions for Expert Witness Evidence, and I agree to be bound by these Directions. To the best of my ability this report has been prepared in accordance with these Directions.

INTRODUCTION

At the commencement of the interview, I explained the purposes of an independent medico-legal examination. I indicated I was not a treating doctor and that I was not able to provide any advice.

My report is based on the history provided by Mr [redacted], the appropriate clinical examination and the documentation provided.

BACKGROUND

By way of summary, Mr [redacted] had injured his lumbar spine on 26 June 2017 while moving heavy trays weighing up to 100 kg, with co-workers. He had developed pain in his low back with referred pain down his left lower limb and it was my opinion on both occasions that he was suffering from S1 nerve root involvement (that is, radiculopathy) as evidenced by the distinct sensory hypoaesthesia. There was also suggestion of a possible L5 nerve root involvement with weakness of extension of his left big toe.

At the time of consultation, I suggested 12% WPI according to DRE Category III of his lumbar spine, and as noted surgical treatment was being considered for him.

You have now informed me that Mr [redacted] has decided that he does not want to proceed with L4/5 discectomy and spinal fusion and have requested an updated WPI.

IDSTORY SINCE LAST VISIT (15 NOVEMBER 2022)

Mr [redacted] attended alone today.

TREATMENT

Mr [redacted] informed me that he has seen two specialists who have recommended surgery for him, but understandably he is very reluctant to consider surgical treatment at this stage.

He continues to take tablets including Panadeine Forte, Brufen, and Nexium, and he still uses a heat pack and a support belt, and he occasionally has a massage. He was having physiotherapy, but not since his payments were stopped in June 2022.

WORK HISTORY

As noted, Mr [redacted] stopped working in December 2017 and has not worked since then.

COMPLAINTS

I read Mr [redacted] his symptoms as he described them to me a year ago, and there has not been any improvement.

He continues to complain of constant pain in his low back radiating down his left lower limb into his left foot particularly the big and second toes. Symptoms can go as high as 8/10. He says he occasionally gets referred pain down his right lower limb particularly if he sits on a hard surface for any length of time.

Symptoms are once agam aggravated by most forms of activity particularly bending and lifting and also jarring. He gets some relief by resting and lying down and the tablets can help for up to an hour.

He is still restricted in walking to 20-30 minutes and only does light housework and manages with his self-care.

GENERAL HEALTH

This is otherwise good.

PAST HISTORY

Mr [redacted] had no problems with his back prior to his injury in June 2017.

EXAMINATION

Mr [redacted] is a heavily built adult male with a prominent abdomen and also the very slight limp on the left side today and is able to walk on heels and toes.

He shows significant restriction of back movement, once again only getting his fingertips as far as his knees, and lateral flexion to the right is slightly more restricted than to the left.

Straight leg raising becomes uncomfortable at 60° on the right and 40° on the left. Reflexes are present and equal, and today he exhibited fairly diffuse hypoesthesia to pinprick of the whole of the left lower limb in a non-anatomical distribution. However, on very careful testing, there was distinct hypoesthesia to pinprick m the Sl distnl:mtion on the left side.

There was also weakness with extension ofhis left big toe compared to the right side.

Mr [redacted] complains of significant discomfort to palpation in the lower lumbar region with mild discomfort on axial loading.

INVESTIGATIONS

Mr [redacted] had a further MRI of his lumbar spine, carried out on 10 September 2022, noting disc desiccation at the L3/4 and L4/5 levels, with a right paraforaminal annular tear and disc bulge. There was no evidence of any neurological involvement.

CONCLUSIONS

My opinions relating to Mr [redacted] remain unchanged from those expressed previously, namely that he has a mechanical problem in his lower lumbar region, but in addition he has evidence of S1 nerve root involvement with distinct sensory loss, and also a suggestion of L5 nerve root involvement with weakness of extension of EHL. There is also restriction in straight leg raising.

It is again my opinion that ongoing symptoms are due to his injury in June 2017.

As far as the treatment is concerned, as noted, he has elected not to undergo any surgical treatment, and apart from avoiding activities that aggravate his symptoms and doing regular exercises and maintaining his general mobility, I would not have felt that anything mote active is indicated at this stage.

As far as employment is concerned, it is once again my opinion that he is not fit for any activities that would place stress on his lower back region, and I would also accept that he is not fit for employment at the present time.

From a prognosis point of view, it is once again my opinion that he is likely to have ongoing problems in the longer term.

IMPAIRMENT

In my opinion, Mr [redacted] falls into DRE Category III of his lumbar spine[1].

This gives 10% WPI. To this I would add an additional 2% for ADLs giving a total of 12% WPI.

Body Part or system	**Date of Injury**	**Chapter, page and paragraph number in NSWworkers compensation guidelines**	**Chapter, page, paragraph, figure and table numbers in AMAS Guides**	**%WPI**	**WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality (expressed as a fraction)**	**Sub-total/s %WPI (after any *dcductioos* in column6)**
l. Lumbar Spine	26 June 2017	Chapter 4, Page 20-25	Chapter 15 Page 384 Table 15-3	12%	Nil	12%
Total¾ WPI (the Combined Table values of all sub-totals)					**12%**	

Please do not hesitate to contact me should you require further information or interpretation of this report.

Yours faithfully

[redacted]

[1] AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Page 384, Table 15-3, Significant Signs of Radiculopathy.

[redacted] **- Orthopaedic Surgeon**