Paul M. Goodman, M.D., F.A.C.S.

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March 10, 2021

Subsequent Injuries Benefits Trust Fund
SIBTF Sacramento
1750 Howe Avenue # 370
Sacramento, CA 95825-3367

Natalia Foley, Esq.
Law Office of Natalia Foley
8018 E Santa Ana Canyon, Suite 100-215
Anaheim Hills, CA 92808

Re:	**BENETIA YOUNG**
Gender:	Female
Date of Birth:	January 8, 1965
Date of Injury:	April 18, 2019
Employer:	Star View Adolescent Center
SIBTF Claim number:	Pending
Evaluation Location:	770 Magnolia #2K Corona, CA 92879
Referring Attorney:	Natalia Foley, Esquire
Evaluation Date:	March 10, 2021

COMPREHENSIVE OTOLARYNGOLOGY SUBSEQUENT INJURY BENEFITS TRUST FUND EVALUATION

To Whom It May Concern:

I am evaluating Ms. Benetia Young on this date for potential SIBTF Benefits in order to determine if there are otologic symptoms which would contribute to her eligibility for SIBTF Benefits, for which the Subsequent Injuries Benefits Trust Fund may be liable.

I have personally taken this woman's history and performed her physical examination.

Ms. Young understands that I am not a treating physician and that no traditional doctor-patient relationship exists.

According to Labor Code 4751, "if an employee was permanently or partially disabled and receives a subsequent compensable injury resulting in additional permanent or partial

disability so that the degree of disability caused by the combination of both disabilities is greater than which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to 70% or more of the total, he or she shall be paid in addition to the compensation due under this code for the permanent partial disability caused by the last injury, compensation for the remainder of the combined permanent disability existing after the last injury".

This shall be billed at the ML-103 level, noting the following:

A) Face to face time with the applicant: 1 hours
B) Record review time: 3 hours (4+ hours [A+B combined] = 2 factors)
C) Issue of causation addressed per request of referring party = 1 factor

SUBSEQUENT INJURY:

Ms. Benetia Young is a 56-year-old woman who was injured on April 18, 2019. She was a youth counselor, shift lead, working at the Star View Adolescent Center. She was checking the youths on a nighttime bed check and was grabbed by a youth, dragged 15 feet on the carpet, and then repeatedly punched in the face and neck. The applicant lost consciousness for several seconds. She sustained injury to the left side of her face and body. She continues to have symptoms including pain on the left side of the temporomandibular joint, ear pain, hearing loss, and pain in the neck, shoulder and left side of her body. She apparently had care with a chiropractor, however, has not had otolaryngologic, dental or other evaluations for her complaints and injuries. Her case was apparently settled in 2019. She has not worked since October 25, 2019.

The rating level is unknown at this time.

PRE-EXISTING DISABILITY:

Ms. Young had no hearing loss or tinnitus prior to the injury. She had no history of temporomandibular joint pain, neck pain or other otolaryngologic signs or symptoms prior to this injury. She denies any history of oral or pharyngeal symptoms. She therefore has in the otolaryngologic field, no evidence of preexisting disability.

OCCUPATIONAL HISTORY:

Star View Adolescent Center from December 2017 to October 25, 2019. She was a Youth Counselor IV and shift supervisor.

Prior to working for Star View Adolescent Center, Ms. Young worked in a similar capacity at Kedren Community Health Center. She did this for several years. In total, she was in counseling for 12 years. Prior to that, she was a hair stylist.

PAST MEDICAL HISTORY:

Ms. Young is hypertensive, has GI difficulties described as gastroenteritis, depression and anxiety.

CURRENT MEDICATIONS:

Amlodipine and Trazodone.

PAST SURGICAL HISTORY:

C-section.

ALLERGIES:

None.

FAMILY HISTORY:

Negative.

SOCIAL HISTORY:

She has one child, age 26. She does not smoke or drink alcohol.

PHYSICAL EXAMINATION:

General:
The applicant is a well-developed woman, appearing her stated age.

Vital Signs:
Height 5’9”, weight 224 pounds, blood pressure 154/106 (patient told to consult her primary care doctor), pulse 62, respiratory rate 20.

Neck:
The neck was supple without adenopathy, masses, or thyromegaly. There are no bruits and the thyroid is normal.

Eyes:
The pupils were equally reactive to light and accommodation with full range of motion of the extraocular muscles and no nystagmus

Ears:
Tympanic membranes and ear canals are normal without evidence of middle ear effusion or disease.

Nose:
Nasal examination reveals a midline septum with the nasal mucosa normal in appearance. There is no drainage, polyps, or purulence noted.

Mouth:
The mouth and tongue were normal without lesions or impaired mobility. The pharyngeal mucosa was normal. The tonsils were not seen.

There is pain on the left TMJ region on facial region. There is pain on opening of the mouth.

DIAGNOSIS:

1. Hearing loss
2. Tinnitus
3. Vertigo
4. TMJ Syndrome

DISCUSSION:

It is apparent that Ms. Young has had various ENT complaints following injury. There were no symptoms of TMJ, hearing loss, tinnitus or vertigo prior to the disability.

PERMANENT IMPAIRMENT RATING PER AMA GUIDES, FIFTH EDITION:

I would therefore state that there is no pre-existing otologic impairment rating indicated with this applicant.

If I can be of any further service please feel free to contact me.

COMPLIANCE STATEMENT

"I personally evaluated this applicant and prepared this report. If others have performed any services in connection to this report, outside of clerical preparation, their name and qualifications are noted herein. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true."

I came to the above opinions based on the current examination findings, available medical records/diagnostic reports for review, credibility of the patient, historical information as provided by the patient and clinical experience both evaluating and treating individuals with the same or similar conditions. This report is signed in San Bernardino County.

Assistance with preparation of this report was provided by Daniela Robinson Assistant and Rapid Care, Record Summarizer, who was trained by Arrowhead Evaluation Services, Inc.

This examination and report is billed at a usual and customary fee, per hour of physician time spent on examination of the patient, review of the medical file and case conceptualization/formulation to answer the questions posed.
Date of Report: March 10, 2021. Signed this 3rd day of June 2021 at San Bernardino County, California.

Sincerely,

PAUL M GOODMAN, M.D., F.A.C.S.
Otolaryngology

PMG/db

Attached: Review of Medical Records

<u>REVIEW OF MEDICAL RECORDS</u>
Young, Benetia
DOB: 01/08/1965

***<u>Job Description</u>**: Employed as a Youth Counselor IV by Star View. Duties: The Youth Counselor is the treatment team member who is responsible for providing direct care to meet the physical and psychosocial needs of the adolescents through direct and indirect physical and verbal interaction. Duties are performed under direct supervision of the Program Manager and Shift Lead; some tasks are accomplished independently.*

<u>Child Care Duties</u>: Supervise, protect and care for children individually and in groups at all times. Promotes and assists adolescents with self-help skills in the areas of eating, hygiene and grooming and other activities. Assist children in working in groups and in handling individual problems. Provide day-to-day supervision and care of children, including assistance with activities of daily living, personal care, planned activities, and school. Models and supports positive youth development and positive behavioral self-management through praise, attention, and use of behavioral incentive system. Attend and participate in morning rounds, change of shift meetings, and treatment team meetings as scheduled on the assignment sheet. Conducts or assists both large and small activity groups. Encourages adolescent's interaction and socialization with other peers, providing feedback to adolescents on appropriate behavior while acting as a role model. L Participate in ProAct Team assignments and activities. Note children's progress in daily progress notes. Make sure children get up each morning; attend to their brushing, toileting, etc. personal hygiene (bathing, tooth. Assist and direct children with making beds, clean their rooms, dressing appropriately and getting ready for school or activities. Get clients to their meals and monitor their eating behavior and dietary intake. Make sure clients get to school each morning, to Day Treatment Groups, and provide supervision while they are in school and groups. Assist clients in making sure they wash their clothes. Assist clients with getting ready for bedtime. Assist with client point cards. Able to participate in agency's efforts to improve quality. Inventory new client's belongings and add and subtract as changes occur. Participates in in-service education as required by State and facility regulations. Transports adolescents or conducts facility business in facility vehicles as directed. This list of duties is illustrative of duties and not a complete list of all duties and assignments that may be required of the Youth Counselor.
<u>Physical Demands</u>: Ability to physically perform containment, escort, and restraint procedures with assaultive adolescents. Ability to physically assist in lifting and carrying assaultive adolescents weighing up to 200 lbs. Ability to visually and audibly assess adolescent's behavior and needs. Ability to walk, run and play active games with the adolescents.

WC Claim Form dated 05/15/18, w/DOI: CT 01/22/18 - 03/09/18. Stress and strain due to repetitive movement, uncomfortable chair, inappropriate lighting, injured shoulders, neck, lower back and LE; stress/depression/anxiety due to hostile work environment.

Application for Adjudication dated 05/31/18, w/DOI: CT; 01/22/18 – 03/09/18. Stress and strain due to repetitive movement, uncomfortable chair, inappropriate lighting, injured shoulders, neck,

lower back and LE; distress/depression/anxiety due to hostile work environment and discrimination based on sex orientation. Nervous system. Employed by Kedren Community Los Angeles Youth Network as a case manage.

WC Claim Form dated 03/14/19, w/DOI: 03/13/19 at 5:30 pm. R thumb. Employed by Star View Adolescent Center.

Employer’s Rpt of Occupational Injury or Illness dated 03/14/19, w/DOI: 03/13/19 at 5:30 pm. Employee assisting in the retraining of a patient. Employee was on the PHF dorm, and was restraining a client, when the client pulled employee’s thumb back. Employee sustained a sprain of R thumb. UE - thumb. Specific injury, Strain. Employed by Star Behavioral Health group & Start View Children as a Youth Counselor. Date Returned to work: 03/13/19.

WC Claim Form dated 04/18/19, w/DOI: 04/18/19 at 08:00 pm. Right side of pt’s body sore, neck, shoulder, and back. Employed by SVAC.

Employer’s Rpt of Occupational Injury or Illness dated 04/22/19, w/DOI: 04/18/19 at 8:00 pm. Employee was doing her normal rounds, and as she walk pass the client, she was assaulted by a resident/client, in hallway of the PHF dome. The employee sustained a cervical strain in her neck area. Neck – soft tissue. Specific injury – strain. Employed by Stars Behavioral Health Group & Start View Children as Youth Counselor. Date Last Worked: 04/18/19.

WC Claim Form dated 05/16/19, w/DOI: 04/18/19 at 8:00 pm. Stress and strain due to repetitive movement over period of time. Neck, shoulder, back, accident on 04/18/19.

Compromise & Release form dated 05/16/19, w/DOI: CT; 01/22/18 – 03/09/18. Entire neck, entire back, B/L shoulders, BLE, stress, anxiety and depression. Employed by Los Angeles Youth Network as a Case Manager. Settlement Amount: $5,000.00 with a deduction of $750.00 for attorney fee, leaving a balance of $ 4,250.00.

Application for Adjudication dated 05/21/19, w/DOI: 04/18/19. Pt was attacked by the patient in the facility, was dragged by her hair, injured neck, shoulder, back. Employed by Star View Adolescent Center as a Shift Lead.

WC Claim Form dated 10/10/19, w/DOI: CT; 04/18/19 – 10/10/19. Stress, anxiety, flashbacks and sleep loss due to attack by a patient at the work place.

Application for Adjudication dated 10/10/19, w/DOI: CT; 04/18/19 -10/10/19. Stress, anxiety, flashbacks, HA, sleep loss due to attack by a patient at the work place on 04/18/19. Employed by Star View Adolescent Center as a Shift Lead.

Joint Compromise & Release form dated 02/15/2020, w/DOI: 04/18/19. Neck, spine, head, HA, shoulders, face, ears, psyche. DOI CT; 04/18/19 – 10/10/19. Psyche, sleep, head, HA and nervous

system. Employed by Stars Behavioral Health Group as a Youth Counselor. Settlement Amount: $25,000.00 with a deduction of $ 0.00 for permanent disability and $3,750.00 for attorney fee, leaving a balance of $21,250.00.

07/10/18 - PTP's Basic Medical Legal Rpt by Harold Iseke, DC. DOI: CT 01/22/18 – 03/09/18. DOE: 06/14/18. Pt sustained on a CT basis from 01/22/18 – 03/09/18. Pt has been employed for a period of two months. Pt started to experience pain in her neck, lower back with radiating pain to the BLE, shoulders, which she attributed to constant sitting and walking. Also developed symptoms of stress, depression and anxiety due to discrimination, overloaded with work and criticized. Reported these symptoms to her employer but no recommendations were given. She managed pain with OTC medication and resting. She continued working with persistent symptoms. Did not see any doctors. On 03/09/18, pt's employment was terminated. Since continued off work and treating on her own at home. C/o frequent, moderate, achy and throbbing C/S, L/S and T/S pain. Also c/o frequent, achy hAs in the occipital region. Loss of sleep due to pain. Due to prolonged pain and feeling like her condition will never improve, she is experiencing anxiety, stress and depression. She states that chemical odors do not occur at work. ADLs: Feel, taste, smell, hear and see without difficulty. ROS: No history of ringing in the ears, hearing loss, congestion or difficulty swallowing. Has HA with slight dizziness. Dx: 1) HA. 2) Cervical S/S. 3) Cervicalgia. 4) Thoracic S/S. 5) T/S pain. 6) Lumbar S/S. 7) Lumbago. 8) Anxiety. 9) Loss of sleep. 10) Depression. 11) Acute stress reaction. 12) Myositis. 13) Chronic pain due to trauma. 14) Myalgia. Causation: Work-related injury. Plan: Recommended acupuncture therapy and Psych consult. Work Restriction, pt is not working.

11/12/18 - Medical Examiner Recommendations by Marc Arnush, MD at U.S. Healthworks. Pt is medically acceptable for the position as a Youth Counselor at Star View Adolescent Ctr based on the PE conducted and Physical Agility Testing.

11/13/18 - Physical Abilities Testing at U.S. Healthworks. Grip and static strength testing was performed. Result: Normal.

03/14/19 – Employee Statement/Supervisor Injury Investigation Rpt. DOI: 03/13/19. While in a restraint inside timeout room on PHF with CX (RF), staff's R thumb was pulled back by CX (RF) causing injury. R thumb pain. Pt did not leave work.

03/14/19 – Work Status Rpt by James Black, PA-at Concentra. DOI: 03/13/19. Dx: Sprain of R thumb. Requested PT. Modified duty. Pt may work entire shift. May push/pull up to 10 lbs occasionally. May grip/squeeze/pinch with RUE occasionally. Wear splint/brace on RUE constantly. Must wear splint on R hand. Caution, cannot defend herself.

03/21/19 – Work Status Rpt by Louis Batch, MD at Concentra. Dx: Sprain of R thumb. Modified duty. Pt may work entire shift. May lift up to 20 lbs frequently. Wear splint/brace on RUE constantly.

03/21/19 – Visit Note by Kenneath Chu, MD at Kaiser. C/o possible shingles onset 2 days. Pain and rash on neck and chest. Pt not sure if drug eruption from Nabumetone prescribed by Workman's comp physician. Dx: Herpes zoster. Rx: Valtrex and Deltasone. Plan: Administered vac. TDAP. Off work from 03/21/19 through 03/25/19.

03/28/19 – Work Status Rpt by Lesette Witherspoon, PA-C at Concentra. Dx: Sprain of R thumb. Modified duty. Pt may work entire shift. May lift up to 20 lbs frequently. Wear splint/brace on RUE constantly.

04/15/19 – Work Status Rpt by Louis Batch, MD. Dx remains unchanged. Modified duty with pt may work entire shift. May lift/push/pull up to 10 lbs frequently. Wear splint/brace on RUE constantly. No restraining

04/18/19 - Employee Statement. DOI: 04/18/19. While completing 8:00 pm rounds. Client (Savannah M.) attacked the pt from the side. Client grabbed pt from the side of head. Right side of pt's head, and lower back were injured.

04/18/19 – Visit Note by Steve Stanford, MD at Concentra. DOI: 04/18/19. Employer: Star View Adolescent Center. Pt works at facility with unruly teenagers (some of which are a danger to themselves and others). 3 hrs. prior a detained female teenager attacked her by pulling and dragging her by the hair, which resulted in a cervical muscle strain. Pt c/o mild intermittent B/L upper back pain at 3/10 along with back stiffness. ROS: ENT: No earache and no hearing loss. HA, but no dizziness and no memory loss. PE: Head/Face: Normocephalic and atraumatic. Eyes: Conjunctiva and lids with no swelling, erythema or discharge. Pupils are equal, round and reactive to light and cornea clear. Extraocular movement intact. ENT: No erythema or edema of the external ears or nose. Dx: Cervical strain. Rx: Ibuprofen. Plan: Requested PT for C/S and back. Modified duty. Pt may work their entire shift. May lift/push/pull up to 15 lbs constantly.

04/19/19 – Dr's 1st Rpt by Steve Stanford, MD. DOI: 04/18/19 at 20:00 pm. Pt c/o head, neck and L shoulder injury, 10/10. Dx: Cervical strain. Modified duty. May lift/push/pull up to 15 lbs constantly. (Partial document.)

08/12/19 - Progress Note by Kenneth Kamfat Chu, MD. Pt presents for PE and with a HA. Has been diagnosed with HTN, on Atenolol outside KP 1 year. ROS: Positive for HAs (tightness in back of neck, admit to stress). PE: HEENT: Mouth/Throat: Oropharynx is clear and moist. Conjunctivae are normal. Neck: Normal carotid pulses present. Dx: 1) HTN. 2) Insomnia. 3) Tension HA. 4) Overweight. Rx: Trazodone, Amlodipine and Ibuprofen. Plan: Pt wants to change Atenolol to different BP medicine. Ordered lab studies.

10/29/19 - Progress Note by Katherine Ross, OD at Kaiser. Pt presents for an eye exam. Distance and near blur without glasses. Dx: 1) Disorder of refraction. 2) B/L glaucoma suspect. 3) B/L age related cataract. Plan: Referred to ophthalmology for glaucoma evaluation. Released spectacle prescription.

10/30/19 - PTP's Initial Eval by Eric Gofnung, DC/Mayya Kravchenko, DC at Eric E. Gofnung Chiropractic Corp. DOI: 04/18/19. While working at her usual and customary duties as a Shift Lead for Star View Adolescent Center, pt sustained a work-related injury to her neck, head, L shoulder and back. She was doing her 15-minute rounds. While walking down a hallway, she was attacked by a client from behind. The client pulled her hair and dragged her 15 ft. through a carpeted corridor and struck her with a closed fist on her head, face and body. A co-worker and a client were wrestled to pull the assailant off. Pt was helped to her feet and assisted in walking to the outside yard. Once she was out, pt fainted for several minutes. When she regained consciousness she experienced numbness and soreness throughout her head, neck, back and L shoulder. The house manager, Michael Trailer, assisted her and recommended medical care. Pt reported to an industrial clinic. Prescribed meds. Off for one day and Ms. Kelly administrator reminded pt what she signed up for and asked when she would return to work. Returned to work and moved to another unit as a floater. She continued working with pain. Returned to industrial clinic and completed 3 sessions of PT. Last seen around 05/2019. Placed on light duty. In 07/2019, presented to PCP, Dr. Chu. Prescribed pain and sleep medication. Pt sought medical care on her own with a masseuse for her neck, R shoulder and back. Attended massage therapy once per week for several weeks. Last time she received massage therapy was in late 09/2019. Currently manages her pain by exercises in water. C/o moderate neck pain and symptoms occur frequently. There is soreness in her neck. There is radiating pain from neck into her shoulder blades, face and head. She has been experiencing frequent HAs. Experiencing N/T or burning sensations on the left side of her face and neck. Has difficulty falling asleep and is often awakened during night by neck pain. There is stiffness and restricted ROM in head and neck. Pain level varies throughout the day. C/o moderate L shoulder pain and symptoms occur frequently. Pain radiates to her arm. Experiences weakness, as well as N/T in shoulder and arm. C/o stiffness and experiences increased pain with repetitive motion of the arm/shoulder. Pain level varies throughout the day depending on activities. Not able to sleep on L shoulder. Moderate T/S pain and the symptoms occur frequently in upper and mid-back. Radiates into her shoulder blades and upper back. C/o tightness in mid back area. There is N/T and muscle spasm. Moderate to severe LBP and symptoms occur frequently in the lower back, which increases becoming sharp and stabbing. Radiates down L buttocks. Has N/T in her back. C/o muscle spasms. Awakens from sleep due to LBP. Self-restricts by limiting his activities. Walks with a limp due to her low back symptoms. Has nausea, difficulty concentrating, dizziness, HAs, numbness of L side on her face. Psyche: Has episodes of anxiety, stress, and depression due to chronic pain and disability status. Pt's condition has worsened due to continued work, lack of medical treatment and ADLs. Difficulty with ADLs. PE: Tenderness at left occipital region. Dx: 1) Cephalgia, closed head trauma, tinnitus L, TBI, rule out. 2) C/S S/S, cervical facet-induced versus discogenic pain, cervical radiculitis left. 3) L/S S/S lumbar face induced versus discogenic pain, radiculitis left. 4) L shoulder S/S. 5) L rotator cuff tear, rule out. 6) L shoulder tenosynovitis and bursitis. 7) Insomnia, anxiety and depression. Causation: Work-related injury. Plan: Recommended chiropractic therapy for C/S, L/S and L shoulder. Also requires x-rays of L shoulder, MRI of C/S, L/S and L shoulder and EMG/NCV of UE. Recommended psychiatric consult with Dr. Musher, and Neurology consult. Modified duty. No repeated flexing, extending,

or rotating of neck. No repeated work with L arm above shoulder height. No lifting in excess of 15 lbs. No repeated bending or stooping. TTD if no modified duty available.

11/18/19 - Dr's 1st Rpt by Gayle Windman, Ph.D. DOI: CT: 04/18/19-10/10/19. Due to an attack by a patient, c/o stress, anxiety, flashbacks, HA, sleep loss, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, SOB and high BP. Dx: 1) MDD, single episode. 2) GAD. 3) Psychological factors affecting other medical conditions. Plan: Recommended CBT sessions. TTD.
11/18/19 – PR-2 by Thomas Curtis, MD at Hamlin Psyche Ctr. Reports continued symptoms of both anxiety and depression. Dx: 1) MDD, single episode. 2) GAD. 3) Psychological factors affecting other medical conditions (stress-intensified HA, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, SOB, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea, possible stress-aggravated high BP). Rx: Wellbutrin, Buspar and Ambien. Plan: Requested CBT psychotherapy. TTD.

11/25/19 – PTP's F/u Report by Eric Gofnung, DC/Mayya Kravchenko, DC. Pt has been undergoing chiropractic manipulations and adjunctive multimodality physiotherapy. Feeling improvement with treatment, however, remains symptomatic. C/o frequent moderate neck, L shoulder, mid back pain. Has frequent and moderate-to-severe LBP. C/o nausea, difficulty concentrating, dizziness, HAs, numbness in left side of face, anxiety, depression and sleep difficulty. PE: Tenderness at left occipital region. Dx remains unchanged. Modified duty.

12/09/19 – PTP's Initial Rpt by Gayle Windman, Ph.D. DOI: CT: 04/18/19-10/10/19. Pt began her employment at Star View Adolescent Center on 12/10/18. Her last day of work there was on 10/25/19. On 04/19/19, pt completed her rounds which included room and bed checks for at risk youths on probation. As she walked down the corridor, she passed two youths. Without warning, one of the youths, Savannah, forcefully grabbed her hair. Savannah pulled her down to the floor and dragged her about 15 feet. She viciously punched her face. Savannah struck her head and face over and over. A client and colleague intervened. She was rushed out of the facility and into the open courtyard. Pt passed out. Savannah once told pt that she reminded her of a mother figure. Savannah's mother committed suicide. Pt filed a police report. Pt was referred to the company doctor. Diagnosed with bruises and contusions. Followed up with Kaiser. Continued to work. Pt was demoted to youth counselor. She could no longer work in the unit where the trauma had transpired. She experienced post-traumatic stress reactions including fear. Pt returned to her job as shift lead. On one occasion, a youth began to bang on the plastic partition. He was in a rage. He attempted to strangle himself. He began to punch pt in the stomach. He was restrained. A co-worker accused pt of instigating the outburst. Pt was accused of making a clinical error. Placed on suspension pending an investigation. She was given the choice to either resign or be terminated. Pt was referred to Eric Gofnung, D.C. Remained symptomatic. C/o depressive mood, anxiety and unprovoked crying episodes. Experienced stress-intensified medical symptoms with worsened HA, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, SOB, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high BP. Experienced post-concussive symptoms including HA, blurred vision, dizziness, faintness,

loss of balance, phobia to bright light and loud noises and ringing in the ears. Due to her mental disorder, experienced impairment in her daily activities. Because of her nervousness, there was increased urinary frequency. There were problems with stress-related constipation and diarrhea. Due to stress-related overeating and depressive inactivity, pt developed a gain of weight of about 70 lbs. Developed decreased sexual interest due to depression, anxiety, withdrawal, irritability, anger and damaged self-esteem. Has difficulty falling and staying asleep due to depression, anxiety, worry and nightmares. Uses Trazodone to fall asleep. Because of her insomnia, pt experienced excessive daytime sleepiness, morning HAs, trouble concentrating and personality change. Because of her cognitive impairment, pt had difficulty communicating her thoughts. Cognitive functioning became impaired such that there was difficulty in her ability to read a magazine or a book and to watch a television show or movie. Pt also had problems remembering. Due to pt's depression and anxiety, there was psychological fatigue and energy depletion. Medical Hx: Pt reported she was diagnosed with migraine HA, irritable bowel, high BP and chronic fatigue syndrome by Dr. Cho. These conditions may have become aggravated by her work stress, in part, as compensable consequences. Psychological tests were administered. Dx: 1) MDD, single episode. 2) GAD. 3) Psychological Factors Affecting Medical Condition (stress-intensified HA, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, SOB, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high BP. Causation: 100% industrial injury. Plan: Requested CBT sessions. TTD.

12/30/19 - PTP' F/u Rpt by Eric Gofnung, DC. Pt is feeling improvement with treatment. She has not returned to work until present. C/o frequent and moderate neck pain, L shoulder pain, mid back pain, and LBP. Also has nausea, difficulty concentrating, dizziness, HAs, numbness in L side of face, anxiety and depression and sleep difficulty. PE: Tenderness at left occipital region. Dx: 1) Cervical sprain. 2) Lumbar sprain. 3) Shoulder tenosynovitis. Plan: Requested electrical stimulation, massage therapy and CMT, L shoulder x-ray, MRI of C/S, L/S and L shoulder, EMG/NCV of UE. Requested Psychiatric consult with Dr. Musher and neurology Consult. (Partial document.)

01/10/20 – AME Rpt by Soheil Aval, MD at West Coast Orthopedics, Inc. DOI: 04/18/19. Employer: Star View Adolescent Center. Pt was making her rounds and that she was walking by two clients. One of the clients snatched her by the back of her hair, and dragged her about 15 ft. This individual then beat her with closed fists with impact to her head and face. Another client came to her assistance and got the assailant off her. A colleague dragged her away from the area and that she had lost consciousness. That night she was evaluated at the Concentra Medical Clinic in Torrance and was given medications. Subsequently attended PT for L shoulder and L shoulder blade, L arm, L side of her neck, and low back. In approximately June 2019, pt presented to Kaiser facility and was evaluated by Dr. Cho. She was having difficulty sleeping due to pain. She was provided with medication only. Pt continued working for the employer until 10/25/19, when she resigned. In approximately 11/2019, pt came under the care of Dr. Eric G. of Los Angeles for neck and low back adjustments. This chiropractor requested an evaluation with a neurologist as she was having ringing in her L ear which was related to the 04/18/19, incident. Has been approved for this and is waiting for an appointment to be scheduled. C/o constant left-sided C/S pain which radiates

to L shoulder and the top of L ear with N/T. Has increased pain when she wakes up in the morning. Some relief of pain with use of med. Constant L shoulder pain that radiates into top of L ear and down the spine to lower back. Some relief of pain with the use of medication. Intermittent left-sided LBP with radiation to the hip and waistline. There is tingling of her low back. She has increased pain with standing and arising from a seated position. The pain is worse when she wakes up in the morning. There is some relief of pain with the use of medication. ADLs: Moderate pain with ADLs. She has ringing of her L ear. Imaging Studies: X-ray of C/S reveals degenerative changes with osteophytes and disc changes at C5-6. X-ray of B/L shoulders reveals the overall osseous density to be normal. Joint spaces are well maintained. AC joint appears normal. No evidence of fracture, dislocation or subluxation. X-ray of L/S reveals mild diffuse osteopenia. Lumbar lordosis is maintained. Degenerative changes are present. Most notable at L3-4 where there is sclerosis of the superior endplate of L4 and some disc space narrowing. Facet hypertrophic changes are present. Dx: 1) Cervical trapezial strain with degenerative disc disease, per x-rays. 2) L shoulder strain; r/o internal derangement. 3) Lumbosacral s/s with degenerative disc disease, L/S; per x-rays. Discussion: According to submitted correspondence, this is an accepted injury sustained on 04/18/19; however, the nature and extent are at issue. The cover letter has captioned dates of injury which include 04/18/19, through 10/10/19, which appears to be a CT. Following evaluation, this examiner recommended she undergo MRI studies of C/S, L shoulder and L/S. Unfortunately, these were not done as pt canceled the appointments and has not responded to re-scheduling of these studies. If she does go on to have MRI studies, will review them and provide additional commentary in a supplemental report. In addition to orthopedic complaints, pt describes sleep difficulties, issues with sexual function and urination, ringing of L ear, stomach upset. She also states she has had to increase her high BP medication. Her BP readings were elevated and she was advised of this. At this juncture, this examiner has not received any medical records. He is recommending the MRI studies and would like to review the records before commenting further. Causation and Apportionment: Pt sustained a specific injury on 04/18/19, when she was assaulted by a client. From her hx, the injury involved her C/S, L shoulder and L/S; however, she also describes ringing of her L ear, psychological complaints and other non-orthopedic issues, which are deferred to the appropriate specialists. Pt's C/S, L shoulder and L/S complaints are consistent with industrial injury of 04/18/19, as described by the pt. This date of injury has been accepted, however, it appears that nature and extent are at issue. X-rays show DDD of both C/S and L/S. Denies prior injuries to the C/S, L shoulder or L/S. Apportionment may be an issue and will be readdressed at the time of final assessment.

02/14/20 – PTP's Record Review Rpt by Eric Gofnung, DC. Discussion and Comments: After review of records, it was noted that the pt is currently under the care of a psychiatrist and additional treatment is being requested. In addition, Dr. Curtis found pt to be on TTD on combined physical and psychological basis as of his 01/21/20 report for two to three months forward. This examiner is in agreement with all of the opinions as expressed by Dr. Curtis. All of the opinions remain the same as stated in prior reporting.

<u>**Deposition of Benetia Ann Young-James, on 10/09/19 (58 Pages).**</u>

Pages 7, 8 – Pt took Amlodipine for hypertension, prescribed by PCP Dr. Chu from a Kaiser in Long Beach. Dr. Chu had been her PCP for about 6 months. She got dry mouth from the hypertension meds. First time he had BP in 2018. Pt felt that medication controlled her hypertension. Pages 9, 10 – Pt also took Trazodone for sleep issues. Pt reported PCP about sleep issues on 04/18/19 and he prescribed medication. Pt spent about 30 minutes with attorney regarding deposition via conference call. Pages 13, 14 – Pt would wear glasses only while doing documentation. As per license, pt's weight was 145 and now it 165 lbs. She stated that she gained little weight with the medication and incident. Currently having pain in right cheek and neck on left side. Pages 15-20 – Pt drove to deposition. Pt would drive 2015 Camry and also owned 2019 Dodge Daytona. She stated that previously scheduled for deposition, but it was cancelled. After currently deposition, she was scheduled to start work by 3 o'clock. Pt previously filed a claim for work compensation case against Kedren Community Los Angeles Youth Network. She first started working for them on 11/18/2015 or 2016 as a case manager in office for 5 or 6 years. Stopped work in 2016 and off work for 2 years. Kedren did a layoff around 2016. Pages 22, 23 – Filed a claim for low back issues at Kedren. Pt stated that she sat all day at work and that caused symptoms. She also had symptoms under bra line. Case was settled. Pages 25-29 – Pt is currently working for Star View Adolescents on regular duties. Pt applied for unemployment benefits regarding lay off in 2016. Pt was hired by Stars on 12/10/18 as a youth counsellor. Pt worked at the adolescent center. Pt's supervisor is Johnny George. Pt had been employed at Early Strides Child Development Center from August of 2018 until the present. Pt was hospitalized overnight when she had a baby around 25 years ago. Pages 31-35 - Dr. Chu also prescribed pain medication. Pt had Kaiser insurance through Stars. At Stars on 04/18/19, while pt was just doing her rounds, going up and down the unit. Before turned back around to do the rounds again to check on all the youth, pt noticed 2 clients on opposite side of her room. At times, a client grabbed the back of pt's hair and dragged her to the ground about 15 feet. Then she turned around to bite and hit her, though other client tried to protect pt. she also struck in pt's face twice on the left side. Employer Imani Ellis witnessed the incident and helped her. Pages 36-39 - Imani carried pt out the back door, and then pt passed out. Then house manager, Michael Trailor asked about her. Pt not continued working that day and filled out incident report. She then went to the company clinic that same day. They gave her pain medicine and sent her to U.S. Healthworks. Then they changed it to Concentra. She stated that doctor took her off for a couple days and returned on modified duties for 4 months. After that, she returned to full duty around mid/late August or early September. After that client was arrested, they gave her position back. Pages 40-43 – Pt stated that in two-day-ago incident, men were able to get the arms of the client. She wanted to continue working at Stars. Pt stated that she is able to do full duty work, and talked to Dr. Spiteri. Pt admitted that physically she is not capable of restraining right now. Pt is having tingle sensation on left side of her face. Pt had a headache since 04/18/19. Pages 44-46 – Pt had symptoms in upper back and shoulder symptoms on the left side based on activities as well as she had symptoms in cheekbones, temple, and back of left neck. She had spasm in mid back around bra line a couple of days ago. Pt would meditate in the morning and do yoga. Pt would get a massage once a week and also water aerobics 4 times a week at Hope. Pages 47-51 – Had seen Dr. Chu twice regarding injury and last visit was 2 months ago. When not working, pt would check on her mother, siblings. Previously, she played racquetball and played golf, but now not able to play at all. She last played racquetball about 3 years ago. Pt

did not play golf for about 6 months. Currently, she could not ride bike due to mild fatigue and hypertension. Pt had some memory issues right now. Pt is addressing more emotional issues than memory issues. Pages 53, 54 – Pt started struggling with completing the documentation. Pt felt that pt's documentation speed had gone down.

NOTE: Remainder of the medical record includes employment records, personnel action form, EMR access request form (EAR), direct deposit enrollment form, form W-4, certificate, personnel record checklist, Donor copy, treatment authorization, missed appointment note, prescription refill, laboratory rpt, call documentation, referral note, ID card, information regarding the hepatitis B, post-employment information, general dynamics/Application report, acknowledgement form, payroll sheet from Star View Behavioral health, Inc., directory, E-Cover sheet, declaration/venue authorization, proof of service, job shadowing training, new employee orientation checklist, letter, request for live scan service – Community Care Licensing, TB screening form.