WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 107/07

BEFORE: J.P. Moore : Vice-Chair

HEARING: January 16, 2007 at Toronto
Oral

DATE OF DECISION: March 8, 2007

NEUTRAL CITATION: 2007 ONWSIAT 620

DECISION UNDER APPEAL: WSIB ARO decision dated March 17, 2004

APPEARANCES:

For the worker: I. Petricone, a Lawyer

For the employer: Not participating

Interpreter: None

REASONS

(i) Background

[1] On July 31, 1996, the worker sustained an injury to his right ankle when his foot became caught in an auger. The injury required surgical repair which was done the next day, August 1, 1996. The Board determined that the worker was left with a permanent right ankle impairment and granted him a 17% non-economic loss ("NEL") award for that impairment. The NEL award for the ankle was increased to 20% in April of 1999.

[2] In 2001, the Board concluded that the worker had developed a psychotraumatic impairment as a result of his injury. He was granted a 30% NEL award for that impairment.

[3] The Board initially determined that the worker would be able to return to work with the accident employer at no wage loss. However, on appeal, an ARO reversed that decision. The worker was subsequently granted labour market re-entry ("LMR") services. An assessment selected a suitable employment or business ("SEB") of Customer Service Clerk. The worker was granted entitlement to a partial future economic loss ("FEL") benefits on the basis of that determination. The worker's final FEL review occurred on September 11, 2002. At that time, the SEB of Customer Service Clerk was confirmed as appropriate and the worker was granted a partial FEL award accordingly, effective September 1, 2002.

[4] In the meantime, the worker had sought initial entitlement for a low back impairment that he attributed to his right ankle impairment. That claim was denied.

[5] The worker objected to the Board's decisions regarding entitlement for the lower back, the quantum of his NEL award for a psychotraumatic impairment, and the quantum of his final FEL review ("R2"). His objection was allowed in part by the ARO in the decision of March 17, 2004. In that decision, the ARO allowed initial entitlement for the lower back but confirmed the 30% NEL award for psychotraumatic impairment and the partial FEL award at R2 based on a SEB of Customer Service Clerk. The worker is appealing the ARO's decisions on the NEL award for psychotraumatic impairment and the R2 FEL award to the Tribunal.

(ii) The issues

[6] The issues in this appeal are:

1. whether the Board correctly determined the quantum of the worker's NEL award for a psychotraumatic impairment;
2. whether the Board correctly determined the quantum of the worker's FEL entitlement on final review, effective September 1, 2002.

(iii) The decision

[7] After reviewing the evidence and the submissions presented to me, I am persuaded on a balance of probabilities that:

1. the worker's NEL award for a psychotraumatic impairment should be increased from 30% to 40%;

2. the worker is entitled to 100% FEL benefits as of September 1, 2002.

(iv) Analysis

(a) NEL quantum

[8] As I noted above, the Board concluded that the worker had suffered a psychotraumatic impairment as a result of his compensable right ankle injury and granted the worker a 30% NEL award for that impairment. The award was based on an assessment done on October 22, 2002 by Dr. P. Butler, a psychiatrist. Dr. Butler's assessment of the worker prompted him to conclude that the extent of the worker's impairment placed him in the "third class of impairment". Under the rating schedule used by the Board to assess mental and behavioural disorders (Document No. 18-05-11 in the Board's *Operational Policy Manual*), a Class 3 impairment allows an award ranging from 20% to 45%. The Board's 30% award placed the worker at the low side of the middle of the range. In her submissions on behalf of the worker, Ms. Petricone argued that the worker ought to have been placed at the top end of Class 3, entitling him to a 45% NEL award.

[9] The Board's policy sets out criteria for consideration of placement in the higher range of Class 3:

> In the higher end of impairment, the worker displays a moderate anxiety state, definite deterioration in family adjustment, incipient breakdown of social integration, and longer episodes of depression. The worker tends to withdraw from the family, develops severe noise intolerance, and a significantly diminished stress tolerance. A phobic pattern or conversion reaction will surface with some bizarre behaviour, tendency to avoid anxiety-creating situations, with everyday activities restricted to such an extent that the worker may be homebound or even roombound at frequent intervals.

[10] Dr. Butler's assessment concludes with the following findings:

> The mental state is of an untidy man who states that he is defeated, that his life is over and that his conditions will not improve. He was cooperative and described his symptoms and history in a matter of fact way. Affect was essentially one of defeat and demoralization. He spoke from a realistic frame of reference. He spoke quietly. As he described the sight of his broken foot and ankle 90 degrees to the rest of the leg when he was lying on the ground with the rain coming down, he was unemotional, as if it was all ancient history.…
>
> His behaviour in the mental state examination and his manner was those of a person resigned to major losses. Thus there has been a great change in his lifestyle and in his aspirations. He also continues to suffer.
>
> I did compare the findings with the criteria of the Board and the American Medical Association. He is capable of some but not all function. He requires assistance in a great many simple activities of daily living like organizing shopping, groceries, finances and so forth. He has no wish to be alive but does not appear to have any active plans to end his life.

[11] Dr. Butler also completed a form described as an "Activities of Daily Living Analysis Form". In that form, Dr. Butler noted that the worker's degree of impairment in four categories was at a level that significantly impeded useful function. Those categories were: emotion, stress, social and leisure.

[12] The form includes hand-written notes that stated that the worker was “very unstable”, “mainly depressed”, “no solutions foreseen”, “friends say he is too nervous”, and that the worker has no leisure activities other than walking to the mall and back. Elaborating on these findings in his report, Dr. Butler noted that the worker does not converse with friends, that he has outbursts of anger that complicate his life and relationships, and that he is “perpetually restless”.

[13] Comparing Dr. Butler’s findings against the criteria in Class 3 of the rating schedule, I am persuaded that the worker exhibits all the symptoms in Class 3 with the exception of bizarre behaviour and being homebound or roombound. Otherwise, I am persuaded that, with respect to those criteria, Dr. Butler’s report shows evidence of at least a moderate anxiety state, definite deterioration in family and social integration, longer episodes of depression, withdrawal from family, and reduced noise and stress tolerance. According to the rating schedule, these symptoms place the worker in the high end of Class 3.

[14] For these reasons, therefore, I am persuaded that the worker ought to have been placed near but not at the top of Class 3. The top of Class 3 warrants a 45% NEL award. In my opinion, 40% is the best estimate of the extent of non-economic loss experienced by the worker as a result of his psychotraumatic impairment. Consequently, I increase the worker’s NEL award for that impairment from 30% to 40%.

(b) FEL entitlement at R2

[15] The Board’s final FEL review concluded that the worker was capable of earning $9.00 per hour as a Customer Service Clerk. That SEB was selected after assessment of the worker’s vocational potential in 1998. Assessments indicated that the worker’s potential to return to competitive employment was impeded by his concerns about pain and his disability. Reports of the worker’s progress in his LMR program indicated that the worker was experiencing increasing frustration with his pain and disability, which in turn affected his performance in his LMR program. The worker stopped his LMR program in April 1999 because he would be undergoing further surgery. The worker did not return to his LMR program after surgery was completed and his file was closed in October 1999.

[16] As I noted above, the Board later granted the worker entitlement to benefits for his psychotraumatic impairment. That occurred in the spring of 2001. In a memorandum dated May 17, 2001, a Board consultant psychologist, Dr. E. Piccolo, noted that the worker had likely “reached a plateau in his rehabilitation”. However, Dr. Piccolo recommended that the worker be referred to a psychological trauma program for evaluation.

[17] The worker began that program on August 14, 2001. The discharge summary was prepared on August 28, 2001 by Dr. S. Shapiro, a psychiatrist. I note the following excerpts from that report:

> [The worker’s] psychological symptoms are of such intensity that he can cope with a gradual RTW [return to work] plan at this time, provided that he does not return to a high stress occupation or work environment.…
>
> We recommend that [the worker] be referred to a pain program to assist with learning coping strategies re: pain management.

[18] The worker was referred to such a program, which he began on October 31, 2001 and completed on November 14, 2001. The worker terminated the program earlier than its intended completion date. Prior to beginning the program, the worker was assessed. A report of that initial assessment, dated October 19, 2001, indicated that the worker presented with "many pain behaviours", and that the "chronic nature of [the worker's] presentation concerns us".

[19] The final report of that program, dated December 18, 2001, indicated that the worker's pain complaints interfered with his participation in the program. The report contained the following behavioural evaluation and conclusions:

> [The worker's] motivation and attitude towards accepting more responsibility and taking a more active role in his recovery was very poor. There was no attempt on his part to comply with treatment goals. He remained extremely angry with all clinicians. He did not apply pain management strategies as instructed and needed constant explanation and encouragement from his treatment team to participate. Indeed, it proved extremely difficult to change his pain perception, his "all or nothing thinking", pain focus and many pain behaviours; he believes that he is "disabled" and cannot return to any gainful employment. Further, the opinion of the treatment team is that secondary gain issues, of which we cannot discern, are at play and will most likely interfere with continued efforts to attempt to create a return to work plan.

[20] In the decision under appeal, the ARO cited the conclusions of the Health Recovery program regarding lack of motivation and secondary gains as a significant factor that the ARO took into consideration in concluding that the worker was capable of working on a full-time basis as a Customer Service Clerk. However, in her submissions on behalf of the worker, Ms. Petricone argued that the behaviour the worker exhibited at the Health Recovery Clinic was not evidence of a lack of motivation and secondary gain but, rather, evidence of his significant psychological impairment.

[21] Ms. Petricone noted that, while the worker had been granted recognition of a psychotraumatic impairment prior to attending at the Health Recovery Clinic, he had not yet been assessed for that impairment. She noted that the findings in that assessment, as described in the evidence from Dr. Butler cited above, indicated that the worker had a level of psychological impairment that would "significantly impede useful function". I note, in this regard, Dr. Butler's concluding statement in his report of October 22, 2002:

> He requires assistance in a great many *simple* activities of daily living like organizing shopping, groceries, finances and so forth. [emphasis added]

[22] Ms. Petricone argued that, if the worker had difficulty with these simple activities of daily living, it is highly likely that he would have difficulty functioning in competitive employment.

[23] Ms. Petricone also submitted that the Board failed to take into account fully the fact that the worker had three distinct impairments: a significant permanent right ankle impairment that required permanent use of a cane, a back impairment that caused the worker reduced mobility and pain, and a significant psychological impairment that I have assessed at a 40% NEL level. She noted that the worker's combined impairment was at a level that approximated the degree of permanent impairment that the Board recognizes as a "serious" impairment that will entitle a worker to additional supports.

[24] I agree with Ms. Petricone's submissions. I am persuaded that the conduct that was described at the Health Recovery Clinic in the course of the worker's pain management program did not reflect a lack of motivation or the impact of secondary gain but, rather, reflected the psychological symptoms described by Dr. Butler in his NEL assessment. It is important, in my opinion, to note that the closing report from the Health Recovery Clinic indicated that the worker was "extremely pain focussed" and "extremely angry". The report also noted that the worker saw himself as being "disabled". These features were all described by Dr. Butler as an aspect of the worker's psychological impairment. As Dr. Butler noted, the worker presented as a person who felt defeated and whose life was "over". Dr. Butler also noted that the worker was "quite frustrated" and very unstable emotionally with "outbursts of anger that complicate his life and relationships, over which he has little control".

[25] The worker has been receiving treatment from a psychiatrist, Dr. D. Slyfield, since 2001. In Dr. Slyfield's first report dated July 13, 2001, he noted that the worker had a complicated fracture of his right ankle in his compensable accident necessitating two surgeries, and that the worker continue to experience "severe pain", as well as "chronic depression and anxiety". In a report dated July 18, 2002, Dr. Slyfield stated:

> As it has been six years since the injury, and his psychological and physical health is not improved, I doubt that he will ever be able to undertake rehabilitation or to return to gainful employment.

[26] On September 9, 2006, Dr. Slyfield prepared a detailed report for the worker's representative. I note the following excerpts from that report:

> Because of [the worker's] pain and his inability to work and lead a normal life, he has become profoundly irritable, depressed, angry and resentful. He also experiences considerable anxiety.…
>
> Over the seven years that I have been treating [the worker] with a supportive type of psychotherapy and antidepressant and anti-anxiety medications, he has demonstrated a slight improvement in the sense that without the medications his suffering would be extreme. But, in no way has he recovered or even substantially improved.
>
> [The worker] has frequently considered suicide but so far has not made any attempts on his life. He has also complained of impotence and his inability to socialize. He is assisted in the activities of daily living by family members, without whom he would be unable to sustain his miserable existence.

[27] It appears to me that, to some extent, the perceptions of the Health Recovery Clinic were affected by the initial assessment of Dr. Shapiro at the Psychological Trauma Program in August 2001. In his discharge report, Dr. Shapiro concluded that there was a "low probability of a permanent psychological impairment".

[28] As subsequent evidence reveals, the worker did, in fact, develop a significant and permanent psychological impairment that, in my opinion, was not fully appreciated in the course of the worker's pain management program at the Health Recovery Clinic.

[29] It is also noteworthy, in my view, that the conclusions of the Health Recovery Clinic in their discharge report seemed to be at variance from an opinion that was communicated to a Board Nurse Case Manager. On October 4, 2001, the Nurse Case Manager wrote the following:

> Spoke to … at health recovery group and they have assessed [the worker] for the pain program. They found him to be pessimistic, angry, disabled mentality and concerned that he may be suicidal. They planned to investigate this further when they have an interpreter… They are unsure if he has [the] insight to succeed with their program. They plan to try him in the program for a few weeks to determine if he makes any progress.

[30] This information suggests that, at the outset of the pain management program, the staff had significant concerns about the worker's ability to function. I am not persuaded that the staff fully understood that these concerns were valid and that the worker's subsequent anger and frustration were not evidence of poor motivation and secondary gain but, rather, evidence of a significant psychological impairment as described by Dr. Slyfield and Dr. Butler.

[31] The worker's accident occurred in 1996. The worker's claim is governed by the pre-1997 *Workers Compensation Act* ("pre-1997 Act"). Subsection 43(3) of that Act stipulates that determining a worker's future loss of earnings requires comparing his pre-earnings with the earnings that he is "likely to be able to earn after the injury in suitable and available employment".

[32] Subsection 43(7) provides guidance in determining what a worker is likely to earn in suitable and available employment. The factors cited include the personal and vocational characteristics of the worker, his vocational rehabilitation prospects, as well as what constitutes suitable and available employment for that worker.

[33] Subsection 63(3) of the Act gives further guidance to the Board, in the exercise of its regulatory power to establish criteria for determining what constitutes suitable and available employment, directing the Board to have regard to:

- the fitness of the worker to perform the work;
- the health and safety consequences to the worker in working in the environment in which the work is performed in light of the impairment;
- the existence and location of potential employment opportunities for the worker in the labour market in which the worker is expected to be employed; and
- the likelihood of the worker securing employment.

[34] Board policy sets out principles and guidelines for interpreting these legislative provisions.

[35] Document No.18-04-02 of the Board's *Operational Policy Manual* sets out the "FEL Presumption" as follows:

> When a worker is unable to return to pre-injury employment because of a work-related injury and is not working at any job at the time of the conditional FEL determination, the WSIB presumes that the worker's future loss of earnings is work-related. However, this presumption can be disproven by
>
> - an actual job offer
> - suitable employment or business…, or
> - a worker's lack of cooperation…

[36] Document No. 07-02-08 of the *Policy Manual* sets out the criteria for determining both the suitability and the availability of a vocational goal. I note the following excerpts from page 2 of that document:

> Once a vocational objective is determined, the caseworker considers whether it is suitable. To determine this, the caseworker must consider whether the worker:
>
> - has the necessary skills to perform the job;
> - is physically able to perform the job; and
> - whether or not the job poses a health or safety hazard to self, or to co-workers….
>
> Determining whether the suitable vocation objectives is available is the final step in identifying a VR objective. To determine this, the caseworker must consider:
>
> - the existence and location of potential employment opportunities in the worker's local labour market, and
> - the likelihood of the worker securing the objective.

[37] In all of the circumstances, I am persuaded on a balance of probabilities that the worker's personal and vocational characteristics, as a result of his compensable injury, were such that there was little likelihood that he would be able to return to competitive employment. In my view, that fact was confirmed by the worker's treating psychiatrist, Dr. Slyfield, after the worker's unsuccessful participation in the pain management program. In his report of July 18, 2002, Dr. Slyfield indicated that he doubted that the worker "will ever be able to undertake rehabilitation or to return to gainful employment". In my view, that opinion is substantiated by the findings of Dr. Butler in the worker's NEL assessment in October 2002, which showed evidence of significant impairment of useful function as well as evidence that the worker required assistance to perform "a great many simple activities of daily living". As Ms. Petricone argued, if the worker was unable to perform a great many simple activities of daily living, there was little likelihood that he would be able to obtain and maintain competitive employment of any sort, let alone in a job that involved interacting with the public as a customer service clerk.

[38] I am persuaded, therefore, that the appropriate determination regarding the worker's FEL entitlement as of September 1, 2002 was that the worker was unlikely to be able to return to employment or have any future earnings. As such, he was entitled to a 100% FEL award as of that date.

DISPOSITION

[39] The worker's appeal is allowed in part.

1. The worker's non-economic loss award for a psychotraumatic impairment is to be increased from 30% to 40%.
2. The worker's FEL entitlement as of September 1, 2002 is set at 100%.

DATED: March 8, 2007

SIGNED: J.P. Moore