WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1620/09

BEFORE: R. Nairn : Vice-Chair

HEARING: February 25, 2011 at Toronto
Oral
Post-hearing work completed June 23, 2011

DATE OF DECISION: October 21, 2011

NEUTRAL CITATION: 2011 ONWSIAT 2420

DECISION(S) UNDER APPEAL: WSIB Appeals Officer decision dated August 15, 1996

APPEARANCES:

For the worker: Ms. R. Lok, Paralegal
The worker's son, witness

For the employer: Closed

Interpreter: Ms. E. Pistarelli, Italian language

REASONS

(i) Introduction

[1] At the time of the accident under consideration here, the worker was employed as a carpenter. Born in 1930, the worker was hired by the accident employer in 1970.

[2] On January 19, 1981, while in the course of his employment, the worker slipped and fell, fracturing his left ankle. The WSIB (the "Board") recognized the worker's left ankle injury as compensable and he was granted various periods of temporary compensation benefits. Subsequently, the Board extended entitlement to include a lumbar strain which the worker had experienced in his fall.

[3] Information on file suggests that in early 1982, the worker was admitted to the Board's Hospital and Rehabilitation Centre for further assessment. In the March 17, 1982, Discharge Report, Dr. D. Bodasing indicated in part:

> **Problems:**
>
> a) Physical: constant pain in his left ankle and his low back.
>
> (…)
>
> **Assessment:** We feel that [the worker's] undisplaced fracture of the left ankle is healed and we do not believe that this should be causing any problems at this stage. He does have degenerative changes in his low back and this could be accounting for some of his discomfort. We do not feel that he is capable of returning to heavy labouring employment.
>
> **Plan:** He is being discharged to modified work. We do not recommend any further treatment or investigations.
>
> **b) Psychological:** When he was admitted to PSEM I felt that this man was depressed and also that he was presenting with a conversion hysteria. At the time of his admission he was started on anti-depressants, Amitriptyline 50 mgs. at night. He had no side effects and appeared to tolerate the medication. He was seen in psychiatric consultation with Dr. Jones on March 16th and he agreed with the above findings and also felt that there was an element of anxiety. Psychological evaluation and test data indicated that [the worker] was depressed, withdrawn, anxious and inadequate.
>
> **Assessment:** We feel that this patient is suffering from a mixed neuroses with components of anxiety, depression and hysteria. We are also of the opinion that his accident contributed towards the development of this mixed psychoneuroses.
>
> (…)
>
> **c) Socioeconomical:** A social work assessment revealed that [the worker] was very preoccupied with his symptoms and lack of enthusiasm but there were no factors evident in the home environment which could be contributing towards his ongoing disability.
>
> (…)
>
> **Discharge diagnosis:**
>
> 1. Undisplaced fracture of the left lateral malleolus, healed.
> 2. Lumbosacral contusion, superimposed on DDD of the lumbosacral spine.
> 3. Mixed psychoneuroses with elements of anxiety, depression, and hysteria. (…)

[4] In testimony provided at this hearing, the worker indicated that he never returned to employment after his accident.

[5] On July 28, 1987, the worker was examined by Dr. J. Horne of the Board for the purposes of determining the degree of his residual physical impairment. In Memo #119, Dr. Horne indicated in **part:**

> **Examination**:
>
> This man looks a little younger than his 57 years. His English is barely adequate.
>
> He walks with a rather bizarre springy little limp favouring his left leg. In reverse this is changed to a bewildered, short step - hoppity gait which includes a little bounce on both bent knees with each step. This is quite an interesting gait but I'm not sure of what it protects or relieves - if anything.
>
> He stands in a few degrees of flexion at the hip with his shoulders hunched a little. He carries a 63.5 kilos in a 153 centimetre frame. The back is surprisingly well muscled with a little exaggeration of the lumbar curve. The abdomen is protruberant.
>
> The trunk movements are virtually nil in all planes. He refuses to walk on toes or heals. He refuses to squat.
>
> Active straight leg raising from the seated position is a bilateral 60 degrees. He is unable to hold this position against resistance.
>
> In the supine position he can lift both legs together to about 10 degrees. In this position he starts resisting passive straight leg raising also at about 10 degrees.
>
> The lower extremities are surprisingly well muscled symmetrically. Motor and sensory testing are both inconclusive because of lack of co-operation.
>
> Virtually all of non-organic signs are present.
>
> **Assessment and Recommendations:**
>
> This man gives a rather bizarre performance with a wealth of non-organic signs but he does appear to have clinical evidence of mechanical low back pain (lumbar facet pain and segmental instability) in keeping with his potbelly lordosis and radiographic signs of degenerative disc disease.
>
> Residual physical impairment is judged to be a minimum 10% with a minor pre-existing factor.

[6] In addition to being granted a 10% permanent disability ("PD") award for his compensable back condition, the Board also concluded that the worker had entitlement for a psychiatric condition which, it was concluded, could be related to the compensable accident and its sequalae. Arrangements were made for the worker to be assessed for the purposes of a non-organic PD award and on December 16, 1988, he was examined by Dr. R. Arbitman, a Board consultant psychiatrist. In the report which followed that assessment, Dr. Arbitman noted in part:

> (…)
>
> His sleep is poor because of the pain. His appetite is poor.
>
> He doesn't do very much. He basically stays at home, sits, goes for short walks and doesn't have any hobbies.

> He is nervous. He worries mostly about finances. He feels depressed. He cries at times. He complains of having no strength. He also complains of headaches which occur sometimes.
>
> He denied any other medical illnesses. There are no major problems at home.
>
> There is evidence of anxiety and depression associated with his complaints of chronic pain. These symptoms are also associated with his inactivity and concerns about his financial situation. It appears that the injury has played some role in his present psychological symptoms.

[7] In light of the opinion provided by Dr. Arbitman, the worker was granted a 10% PD award for his psychiatric condition.

[8] On October 20, 1990, the worker was injured at home when some bricks fell on him while he was inspecting a basement he was having built. In a Discharge Report dated November 9, 1990, Dr. A. Kasses of the Toronto Hospital noted:

> This 60 year old gentleman was admitted on October 20 following trauma sustained to the right side when 200 pounds of bricks fell on him. He presented to the emergency department with an unstable open book fracture of the right pelvis and a dislocation of the right iliosacral joint. After he was assessed by the trauma team he was taken to the OR for application of external fixator with an A-O frame and pins through both iliac crests.
>
> On October 22nd the patient had a respiratory arrest with hypotension. He was intubated on the floor and transferred to the med-surg ICU where a PQ scan was positive for pulmonary embosis. He was treated with IV fluids, Heparine and close monitoring. (…) X-ray follow-up of his pelvic fracture showed a complete displacement of the unstable open fracture and more x-rays taken of his right hand showed a displaced distal fracture of his right ulna. We decided to take the patient to the OR for reposition of his frame and open reduction and internal fixation of his right forearm on the afternoon of October 30th. (…) Post operative course after the second OR was completely uneventful, the patient was kept on profolatic anti-coagulation to prevent a second pulmonary embosis. He was protected with a cast on his right forearm. He was treated for a urinary tract infection with IV ancef with complete relief and finally he was transferred to Hillcrest Hospital where he was continued on close nursing care.

[9] As noted in Memo #157 of September 20, 1990, just prior to the non-compensable accident, a Decision Review Specialist had recommended that the worker have his PD awards reassessed given that he had not been examined for a couple of years. Those reassessments were postponed because of the worker's accident in October 1990. In Memo #164 dated November 27, 1991, Dr. W. Little of the Board recommended that the reports from the worker's most recent stay in hospital be reviewed before any decision was made about reassessing the worker's PD awards.

[10] In Memo #168 dated May 11, 1992, a Board Adjudicator advised Dr. Little:

> I don't see how we can bring this worker in now noting the non-compensable accident he's had involving the low back. We would, in effect, be measuring his subsequent non-comp residual impairment as well.
>
> Is there any way we can use the medical information on file subsequent to the pension exam of July 1987 and before the October 1990 non-compensable accident and

> estimate, by paper review, the best pension percentage to reflect the level of low back impairment?
>
> Your medical opinion appreciated.

[11] Dr. Little responded by indicating "File reviewed again. Would confirm REC organic award".

[12] In a decision dated June 8, 1992, the Claims Adjudicator indicated:

> (…)
>
> Your file has been reviewed by a senior medical consultant at the Workers' Compensation Board. From the medical information reviewed by the consultant, your condition for the non-compensable accident has not stablized. In addition, your non-compensable accident has involved your low back. In arranging for a permanent impairment reassessment, it would be impossible to measure your compensable disability against the non-compensable permanent injuries from the accident of October 20, 1990.
>
> Our senior medical consultant has carefully reviewed the medical reports submitted to your file between July 1987 up to June 4, 1990 the date of the last medical report on your file prior to your October 20, 1990 accident. From the information provided in these medical reports, our medical advisor has noted that there is no evidence that your compensable condition has changed and the permanent impairment award that you presently receive under this claim of 20% is confirmed.
>
> In conclusion, your non-compensable accident of October 20, 1990 is significantly affecting your present level of disability. The 20% permanent impairment award for your compensable condition is confirmed by the medical reports in your file up to June 1990. We will not be arranging for a permanent impairment re-examination as the assessment would only be measuring your non-compensable permanent disabilities which are not covered under this claim.

[13] In a decision dated May 3, 1995, the Claims Adjudicator confirmed the prior conclusions and indicated:

> (…)
>
> Your permanent impairment prior to this non-compensable accident is 10% for the residual problems with your back as a result of the accident on January 19, 1981 and 10% for non-organic features. It has been determined that your non-compensable injuries from October 1990 are significantly affecting your level of disability. The 20% permanent award that you received for your compensable condition is confirmed by the medical reports in your file up to June 1990. A 20% award is again confirmed for life as an up to date assessment would only be measuring your non-compensable problems which are not covered under this claim.

[14] The worker objected to the Board's decision with respect to the quantum of his PD awards and the issues were eventually forwarded to an Appeals Officer. Prior to considering the matter, the Appeals Officer requested a medical opinion on the issue of the 10% award for the worker's back disability and noted the following in Memo #189 of June 17, 1996:

> (…)
>
> Based on the medical reporting on file, would you agree that the 10% pension award adequately reflects the level of permanent disability residual to the January 19, 1981 accident? Also, in this case, would it have been reasonable to have expected further

> deterioration in the back? If so, would it be reasonable to grant the worker an additional 5% award to recognize future deterioration.

[15] Dr. Little of the Board responded "Reviewed. 1. Yes, 2. Yes - possibly, 3. Yes - possibly".

[16] The Appeals Officer also asked for a medical opinion on the issue of the appropriateness of the 10% PD award granted for the non-organic condition and in Memo #192 dated July 29, 1996, Dr. M. Harminc, the Manager of the Board's Psycho-social Services, concluded:

> (…)
>
> **Opinion**
>
> To address your concerns as stated in memo #190, it is my opinion that the worker's difficulties have been adequately reflecting his level of disability as related to the compensable injury. One can hypothesize that the second, non-compensable injury in 1990, was much more psychotraumatic, especially with respect to respiratory arrest and pulmonary embosis. It is suspected that the second accident and its consequences have significantly affected his level of psychiatric disability as reflected in the latest psychiatric reports. It is my opinion that a pension reassessment of his non-organic award is not warranted, considering the above stated variables.

[17] The Appeals Officer also asked for a medical opinion on other issues raised by the worker including a PD award for his ongoing left ankle problems and whether the worker ought to be granted entitlement to benefits for plantar fasciitis (and associated orthotics) which, it was claimed, could be related to the compensable left ankle injury. In Memo #191[1] Dr. Malayil noted in part:

> (…) Further medical reports indicate ongoing left ankle and leg pain with favouring of the left leg but there was no evidence of any organic pathology to support the ongoing complaints of pain in the left ankle. He was assessed at the PSEM unit at DRC and the discharge report of March 17, 1982 indicated that worker had entitlement for both residual organic and psychological problems. Accident related psychiatric disability was accepted. Worker is receiving a 10% award for the non-organic disability.
>
> It is noted that worker suffered non-compensable injuries to the pelvis and right upper extremity. There was a fracture of the right pelvis and right ulna. The right pelvic fracture was treated by close reduction and the right ulnar fracture was treated by open reduction and internal fixation on November 9, 1990.
>
> A report was received from a chiropodist/foot specialist (December 28th, 1994) indicating that worker has bilateral pes planus deformity with acute plantar fasciitis on the left side. He related the condition to the compensable left ankle injury of January 1981.
>
> Based on the medical evidence we have on file at the present time it would not appear that there was a serious injury to the left ankle. Worker sustained an undisplaced fracture of the lateral malleolus initially and it was treated in a plaster cast with complete healing. Although worker was complaining of ongoing pain in the left ankle and leg different orthopaedic specialist's reports did not indicate evidence of any organic pathology to support the ongoing complaints of pain in the left ankle. There

[1] A complete copy Memo 191 was obtained from the Board after the hearing. A copy was provided to Ms. Lok and she was given the opportunity to make further written submissions on it. Those submissions, which have been reviewed, are located in Post-Hearing Addendum No. 2 of June 22, 2011.

> was no mention of any plantar fasciitis up until December 1994, almost fourteen years following the compensable left ankle injury of January 18th, 1981. The foot specialist's report indicates that worker has bilateral pes planus deformity which is a risk factor for plantar fasciitis. In the absence of any structural damage to the left foot due to the compensable injury, I find it difficult to relate the plantar fasciitis to the compensable injury and as such the orthotics recommended by the foot specialist is not related to the compensable injury.
>
> As I have indicated earlier in this memo, the different orthopaedic surgeons who saw the worker could not detect any organic basis for worker's ongoing left ankle pain and therefore it is not felt that the compensable left ankle injury of January 19th, 1981 resulted in a permanent disability in the left ankle on an organic basis.

[18] After considering the medical opinions provided, the Appeals Officer issued a decision dated August 15, 1996, in which she denied the worker's appeal. With respect to the issue of the 10% organic PD award, the Appeals Officer concluded:

> I agree that a pension re-assessment in this case would not be worthwhile, given that it would be difficult to measure the residual disability related to the work injury because of the significant non-compensable accident of October 20, 1990.
>
> I have reviewed the medical reporting prior to October 20, 1990, and find that the physical findings are similar to those reported by the Board's examining doctor on July 18, 1987.
>
> (…)
>
> I am satisfied that the 10 per cent pension award adequately recognizes the permanent organic low back disability residual to the January 19, 1981 accident.

[19] With respect to the issue of the 10% non-organic PD award, the Appeals Officer concluded:

> I agree with the opinion of the manager of Psycho-Social Services, and accept that although there is evidence that the worker's level of psychiatric disability has increased since the assessment, I am unable to relate the deterioration to the work injury, given the psychotraumatic non-compensable accident of October 20, 1990. I am satisfied that the 10 per cent pension award adequately reflects the non-organic disability resulting from the January 19, 1981 accident, and the request for a reassessment is therefore denied.

[20] With respect to the issue of ongoing entitlement for the left ankle, the Appeals Officer was of the view that the medical evidence did not support "an ongoing left ankle disability on an organic basis as a result of the January 19, 1981 accident". The Appeals Officer also denied the worker entitlement for the plantar fasciitis noting:

> Although the worker is claiming entitlement for plantar fasciitis, it is difficult to relate this condition to the January 19, 1981 accident, given that the medical reporting does not support an organic disability in the left ankle on an organic basis, as well as the fact that there is no mention of the plantar fasciitis until December, 1994, almost 14 years following the original injury. The medical reporting does not support any structural damage to the left foot as a result of the January 19, 1981 accident, and, therefore, entitlement for the plantar fasciitis and the orthotics recommended by the foot specialist are not found to be related to the original injury.

(ii) Issues on appeal

[21] The issues to be determined in this case are:

(a) Whether the worker is entitled to a re-assessment of the 10% PD award granted for his organic low back condition?

(b) Whether the worker is entitled to a re-assessment of the 10% non-organic PD award?

(c) Whether the worker is entitled to a PD award for an ongoing left ankle problem which he claims can be causally related to the compensable accident of January 19, 1981?

(c) Whether the worker is entitled to benefits for left plantar fasciitis and related orthotics which he claims can be causally related to compensable accident of January 19, 1981.

(iii) The worker's testimony

[22] In his testimony, the worker confirmed that he came to Canada from Italy in 1956. Since starting work at the age of 14, he has always worked as a carpenter.

[23] The worker advised that prior to his accident in 1981 he had always had a very good relationship with his family (which consisted of a wife and three children). The family ate meals together and he played with his children in the park. They socialized frequently with friends and relatives.

[24] The worker testified that in addition to injuring his left ankle and back in the 1981 accident, he also began to experience depression. He also had constant pain radiating from the bottom of his left foot up into his back. He never had any similar problems prior to the accident in 1981 and indicated he worked "like a dog".

[25] After the accident in 1981, the worker's relationship with his wife changed. With his feelings of depression, he often pushed her away and could not stand to be around her or the children. Since 1981, he feels as if he has no children and they mean nothing to him. He has cut them out of his life because he has to deal with his constant pain, depression and worries.

[26] The worker described the non-compensable incident in October 1990 and indicated that he and his wife had decided to have a veranda built at the front of their house. Workers were hired to perform the work. One day, the worker went out to see how the job was going and walked through the area that was being excavated. As he did so, a 12 inch by 12 inch block of cement, about a foot high, fell on his left thigh. The worker recalled being taken to hospital and undergoing surgery. He recalled being in hospital for about four months and suggested it was another six to seven months before he recovered.

(iv) Testimony of the worker's son

[27] The worker's son testified that at the time of the compensable accident in 1981, he was about seven years old. He recalled his parents having a very affectionate and supportive relationship. He and his parents often went to the park, played soccer together, attended church and the CNE. He described his father as being playful and happy, always hugging and kissing and encouraging him.

[28] After the accident in 1981 however, the relationship with his father changed quite a bit. His father was no longer playful and affectionate but was more withdrawn and distant. His

father became very nervous and had frequent outbursts of temper, often spanking them over very minor matters.

[29] The worker's son described him as a "sick dog" who would lie on the couch all day complaining of pain. He was very depressed, detached and became very introverted. He would be crying in pain all the time. The worker's son also noted that his father's relationship with his wife changed as well. They were no longer as affectionate and did not do things together. The worker's son recalled his father essentially being homebound. He never went out unless he absolutely had to. His father seemed afraid to interact with others.

[30] At the time of the home accident in 1990, the worker's son was about 16 years old. He remembered that workers were excavating an area below the front porch in which they were going to make a cold room. His father was walking through the excavation when a number of bricks fell on him, fracturing his pelvic bone. The worker's son suggested that the estimate of the bricks weighing 200 pounds was much too high.

[31] The worker's son was asked about changes in his father's behaviour after the accident in 1990 and he suggested that his father was "so far gone" by that point that there was really little change in his situation. His father was already very depressed and upset with life because he was no longer working. His job had been very important to him and when he could no longer work, he felt his father did not care whether he was dead or alive. The witness confirmed that his father was taken to hospital after the accident and had surgery almost immediately. He suggested it was seven or eight months before his father stopped complaining about his pelvic pain.

[32] The worker's son testified that now, his father continues to be very sad and does not care about enjoying life. He spends most of his time lying on the couch and moves only from his chair to the kitchen. Most of his time is spent in the basement.

[33] The worker's son suggested that there was a noticeable deterioration in his father's condition a few years after the 1981 accident when he realized he would not be able to return to work. He had always taken great pride in doing his job and when that was no longer possible, he felt as if he were not a man or a father.

[34] With respect to the incident in 1990, the worker's son suggested that the pillar which fell on him consisted of bricks that had been cemented together and were about waist high. He suggested the incident was not a life threatening event and recalled his father being in hospital for about three weeks and then undergoing rehabilitation for a few months. The witness thought that the accident in 1990 may not have occurred at all had his father been more mobile.

(v) Analysis

[35] Since this worker was injured in 1981, the applicable legislation is the pre-1985 *Workers' Compensation Act.*

(a) PD reassessments for the organic and non-organic awards

[36] Board *Operational Policy Manual* ("OPM") Document No. 15-05-04 entitled "Non-Work-Related Conditions - Reduction or Suspension of Benefits" provides in part:

> **Policy**
>
> A worker's level of compensation benefits may be affected by the presence of a non-work-related condition.
>
> **Guidelines**
>
> If any non-work-related condition (e.g., pregnancy, hernia etc.) is preventing a worker from undergoing treatment for the work-related injury, compensation benefits may be reduced or suspended until the worker is available for treatment of the work-related injury.
>
> If the non-work-related condition is not affecting or impeding the treatment of the work-related injury, it has no bearing on the level of compensation benefits payable to the worker.
>
> If the non-work-related and the work-related conditions are both contributing to the ongoing disability/loss of earnings, full compensation benefits are continued until the level of work-related disability/loss of earnings is clinically determined, at which time continuing compensation is paid commensurate with the degree of remaining work-related disability/loss of earnings.
>
> If it is clinically established that the sole cause of the continuing disability/loss of earnings is due to the non-work-related condition, and no permanent disability/impairment from the work-related condition exists, benefits cease.
>
> **Application date**
>
> This policy applies to all decisions made on or after July 26, 1990, for all accidents.

[37] As a review of the Appeals Officer decision makes clear, the Board's decision to deny the worker's request to have his organic and non-organic PD awards reassessed was based, in essence, on a finding that the incident at home on October 20, 1990, broke the chain of causation between the 1981 compensable accident and the worker's subsequent problems.

[38] Where there is a non-compensable accident which follows a compensable accident and its impact is so significant on the resulting disability that it breaks the chain of causation between the compensable accident and resulting disability, it will be considered to be an "intervening cause" which would undermine entitlement to benefits (see for example *Decision Nos. 1755/02, 1222/01* and *176/00*).

[39] *Decision No. 327/96* examined the issue of "intervening cause" in a situation where the matter in dispute involved a determination of whether a disability was caused by a compensable accident or a subsequent non-compensable accident. In reviewing previous Tribunal decisions, it commented in this regard and indicated:

> A number of Tribunal decisions have dealt with the question of whether disability following a non-work accident is compensable[1]. In deciding whether workers are entitled to benefits for disability suffered following a non-work accident, Tribunal panels have asked: Was the original compensable injury a significant cause of the disability suffered by the worker after the subsequent non-work accident? or, was the non-work accident a subsequent intervening cause such that the disability suffered by a

> worker following the non-work accident ought no longer to be attributed to his/her original work injury? Did the non-work accident break the causal link between the compensable injury and the subsequent period of disability?

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[1] For example, Tribunal *Decision No. 569/92*, (1992) 24 W.C.A.T.R. 277 and the decisions cited therein at page 283.

[40] After considering all of the information before me, I am satisfied that while the accident at home in 1990 likely played a role in the worker's current state of health, it was not sufficiently significant to break the chain of causation between the 1981 accident and the worker's ongoing problems. Put another way, borrowing from *Decision No. 327/96*, I am not satisfied that the events of 1990 were so significant that they justify concluding that the disabilities suffered by the worker post-1990 can no longer be attributed to his original work injury. In reaching this conclusion, I have taken particular note of the following:

- Reviewing the reporting on file, it appears that the Board's conclusions about the severity of the incident in October 1990 have been based in large part on the description of the incident as one in which the worker had "200 pounds of bricks fall on him". This description, noted in the 1990 medical reports, has been repeated throughout the life of this file. After considering the matter however, I am satisfied that this version of the events of October 1990 is somewhat exaggerated. In this regard, I accept the testimony provided by the worker's son (who would have been about 17 years of age at the time) to the effect that this was not a life threatening event and the worker was not, as some of the reporting suggests, buried beneath a load of bricks. The incident actually involved a pillar of bricks which had been mortared together (about 12 inches by 12 inches by a couple of feet high) falling onto the worker's side. As the worker's son indicated, had his father's mobility not been restricted by his compensable injuries, he may well have been able to avoid the falling bricks.
- In his testimony, the worker's son confirmed the evidence given by his father to the effect that while he did sustain injuries to his pelvis in the 1990 incident, he eventually recovered from those injuries. This testimony is supported by the opinion provided by the worker's family physician, Dr. Kumra, in his report of August 15, 2010. In that report, Dr. Kumra, who had been the worker's family physician since 1991, noted:

  > The injury related to a load of bricks falling on [the worker's] pelvis in 1990 was reviewed and examined by myself in 1991 with an explanation of the findings presented in person by Dr. Artinian himself at the time. It was Dr. Artinian's feeling and opinion at the time from my recollection that the injuries sustained were related to contusional injuries with an associated fracture pelvis and was not back related. The injuries were ultimately resolved over time in the 90s. His diagnosis was a fractured pelvis. His prognosis from those injuries was excellent by 2000. The current 2010 x-rays show very little evidence of a fractured pelvis.

- In a report dated June 20, 1991, Dr. J. Davey of the Toronto Hospital noted:

  > X-rays show good healing of the right ulnar fracture. (…) The right ilium and sacroiliac joint fractures have gone on to heal. There is approximately two centimetres of vertical displacement of the right hemipelvis.
  >
  > [The worker] is gradually improving. He feels the old injuries to the low back and left leg have slowed his progress. (…)

- In a report dated February 12, 2010, Dr. P. Wang (general practitioner) noted in part:

  (…)

  4. [The worker] first complained of his back at his first visit to me March 12, 2000.

     a) the diagnosis at the time was work-related back injury, chronic.

     b) the prognosis was poor

  (…)

  8. The injury of 1990 when a load of bricks fell on his back also contributes to his diagnosis. However, this exacerbation doesn't negate the effect of the original workplace injury of 1981.

- With respect to the worker's psychiatric condition, I note the testimony of his son that he noticed little change in his father's condition before and after the events in 1990. He suggested that his father's psychiatric condition had taken a turn for the worse a few years after the accident in 1981 when it became apparent he would not be able to return to work. He suggested that his father's condition has continued to deteriorate since then.

- In a report dated March 1, 2010, Dr. A. Sanchez (psychiatry) noted that "the patient has a tendency to feel depressed since 1981, when he had a work related accident".

[41] In light of the information outlined above, I am satisfied that the Board erred in concluding that the non-compensable accident in October 1990 broke the chain of causation between the 1981 compensable accident the worker's ongoing organic and non-organic symptoms. While the 1990 incident may have contributed to the worker's ongoing problems, I am satisfied that that incident was not sufficiently severe to warrant a conclusion that the compensable accident did not remain a significant contributing factor in the worker's ongoing problems.

[42] OPM Document No. 18-07-01 entitled "Determining the Degree of Disability" provides in part:

> (…)
>
> **Re-assessment**
>
> If a permanent disability worsens, the WSIB may reassess the worker's disability. Additional disability developing subsequently is determined by physical examinations which may be made from time to time. (…)

[43] In this case, I am satisfied that the evidence establishes that both the worker's organic and non-organic conditions have worsened since his PD awards were initially granted and he is entitled to have those awards reassessed. With respect to the worker's back condition, I would note:

- The worker has not has his back condition assessed since 1987 when he was examined by Dr. Horne of the Board.

- In his response to the questions from the Appeals Officer in Memo #189 of June 17, 1996, Dr. Little of the Board answered "yes - possibly" when asked whether it would have been reasonable to increase the worker's PD award by 5% to recognize further deterioration.

- In his report of February 12, 2010, Dr. Wang indicated:

> In my opinion, the 10% disability pension award granted in 1987 doesn't adequately reflect the back disability. Due to progressive worsening of his condition, he has lost much more function since the award granted.

- In his PD assessment, Dr. Horne noted that "active straight leg raising from the seated position is a bilateral 60 degrees".

- In a report dated October 2, 2008 Dr. Wang indicated:

> I am writing to request coverage for an orthopaedic mattress for [the worker] as he suffers from severe low back pain from a work injury. Objective evidence for his impairment includes findings on physical examination. His spine is tender from L1 to L5 with paralumbar muscle tenderness bilaterally. Straight leg raising is only 30 degrees bilaterally. His lumbar spine range of motion is severely decreased, and he can bend over only to touch his knees. (…)

[44] Similarly, with respect to the worker's psychiatric condition, I note:

- The worker's psychiatric entitlement has not been reviewed since the PD award was first granted prior to the incident at home in 1990. As noted in a memo dated September 20, 1990, a Decision Review Specialist had suggested "prior to the incident at home" that "as worker has not been seen since 87 he may wish to arrange reassessment to give worker benefit of up-to-date assessment". This reassessment never took place because of the intervening October 1990 incident.

- The worker currently has a 10% PD award for his psychotraumatic entitlement. OPM Document No. 15-04-02 entitled "Psychotraumatic Disability" provides that a 10% PD award represents a "minor impairment of total person". The policy suggests:

> In this category, the injured worker's daily activity is slightly limited and no apparent difficulties are reported in personal adjustment. There is also some loss in personal or social efficacy and the secondary psychogenic aggravations are caused by the emotional impact of the accident.
>
> A mild anxiety reaction is apparent. The display of symptoms indicate a form of restlessness, some degree of subjective uneasiness and tension caused by anxiety. There are subjective limitations in functioning as a result of the emotional impact of the accident. The disability, from the psychiatric point of view, is not expected to be permanent.

The evidence available to me suggests that the worker is displaying psychiatric symptoms beyond the slight limitation in daily activity and personal adjustment suggested to be reflective of a 10% PD award. The testimony of the worker and his son suggests that for some time, the worker has essentially withdrawn from his family, remains housebound or even roombound and does little other than rest or move between his chair and the kitchen.

- In his report of August 15, 2010, Dr. Kumra noted:

> In my opinion, the 1981 injury played a significant role in his current psychiatric and physical diagnosis. The 10% disability pension granted at the time poorly reflected his disabilities. It is my firm opinion, that [the worker] suffers from psychiatric problems such as medically intractable major depression that is permanent given the length of time that has passed. In fact, his state presently consists of severe anxiety, definitive

> deterioration in family adjustment and social integration. His present activities in fact make him homebound.
>
> In summary his current psychiatric and physical diagnoses are a direct result of his 1981 injuries in my opinion. I believe that [the worker] should be compensated at a 30-50% level for psychiatric related diagnosis and an equal organic disability percentage readjustment for the back.

- In a report dated March 1, 2010, Dr. Sanchez indicated:

> (…)
>
> His complaints are about the same as they were in 1995: anxiety, tension, depression, loss of interest and pleasure in the usual activities of life. He stays mainly at home, does not socialize. He is forgetful, does not eat much, he lost weight. He has problem to sleep, he is tired, has problem to concentrate, he is being slowed down, and feels that he is good for nothing.
>
> He hears voices threaten to kill him. He reported that he heard these voices for a very long time, but did not report it during his previous visits. He avoids to see his friends, has very poor tolerance to noises and to frustration. He avoids anxiety creating situations, which seems to be the reason why he never tried to appeal the WSIB before.
>
> He is isolated, homebound, withdrawn, forgetful, unable to concentrate and needs continuous emotional support within the family. There is an obvious loss of interest in his environment. At times he is irritable. He is severely depressed with psychomotor retardation.
>
> The patient has a tendency to feel depressed since 1981, when he had a work-related accident. (…)
>
> However, in view of his deterioration, he has been referred back to me. It is not clear when the deterioration started. He mentions that when he came to see me before he was having auditory hallucinations, but it was not reported.
>
> (…)
>
> The patient is suffering from A Pain Disorder Associated With Psychological Factors and A General Medical Condition, and a Major Depressive Disorder with Psychotic Features.

- In a report dated September 5, 1995, Dr. Kumra advised:

> I have had the opportunity to examine [the worker] before as well as after the accident. It is important for you to realize that since the accident date of 1981 that [the worker] was in the process of undergoing a further reassessment of his injuries. I was in the process of preparing this information. However, an accident of October 1990 delayed this due to injuries that you have already obtained in your medical records. I will attempt to show you that prior to October 1990, [the worker] had undergone significant organic and non-organic damages related to his 1981 accident. I hope this will help you in the assessment of this claim. I also hope that this will help you differentiate the discomfort that he felt as a result of the non-compensable accident as opposed to what he felt prior to the non-compensable accident.

[45] In summary, after reviewing the information on file, I am satisfied that the incident at home in October 1990 did not break the chain of causation between the compensable accident and the worker's ongoing back and psychiatric conditions. In my view, the balance of evidence supports a finding that both of these conditions have worsened since the PD awards were granted and that the worker is entitled to have these conditions reassessed. Given that the Board has never directed its mind to the question of the appropriate PD award to be granted (having

decided that the incident in October 1990 broke the chain of causation), I am satisfied that the most appropriate course of action would be to return the matter to the Board to have it adjudicate the matter in light of the conclusions reached in this decision.

(b) A PD award for the left ankle

[46] As noted earlier in this decision, the Board recognized that the worker fractured his left ankle in the compensable accident of 1981. However, after reviewing all of the information before me, I am not satisfied that the balance of evidence supports a conclusion that the worker has continued to experience symptoms which can be causally related to that accident. In reaching that conclusion, I have taken particular note of the following:

- In a report dated February 22, 1982, Dr. D. Bodasing of the Board noted:

  > Problems:
  >
  > a) Physical: constant pain starting in the left ankle and progressing proximally into his low back.
  >
  > Assessment:
  >
  > Today's examination failed to reveal any disabling organic pathology. This patient did have an undisplaced fracture of the distal end of the left fibula and this is healed completely. There is no evidence of any ankle instability or joint swelling nor is there any evidence to suggest any Sudeck's dystrophy (…)
  >
  > Admission diagnosis:
  >
  > 1. Fracture of the left lateral malleolus - healed (…)

- In a report dated March 8, 1982, Dr. I. Harrington (orthopaedics) noted:

  > (…)
  >
  > X-rays of the lumbosacral spine, left tibia, and ankle taken October 21, 1981 were reviewed. Minor degenerative changes are noted in the lumbar area. Films of the ankle show the fracture completely united. I am unable to see the fracture line. The ankle mortise is intact. There is no evidence of degenerative change.
  >
  > I am unable to find any definitive orthopaedic pathology related to [the worker's] back or ankle. He showed a number of inappropriate responses during the examination today including hypoesthesia to pinprick involving the entire left leg, distributed in glove and stocking fashion distal to the hip. The main problem with this workman is of a functional nature.

- The worker was discharged from the Board's Rehabilitation Centre in March 1982 with a discharge diagnosis of "undisplaced fracture of the left lateral malleolus, healed".

- In a report dated September 17, 1982, Dr. J. Jimenez (physiatrist) noted:

  > This is to inform you that the bone scan of this patient show the presence on an increased uptake in the right intertarsal joint; the left foot and the rest of all the joints were normal.
  >
  > In summary, the bone scan findings do not help interpretation of this patient's pains and the increased uptake is in the right foot and he has the pain in the left.

- In a report dated March 17, 1983, Dr. G. Conn (orthopaedics) indicated:

> I am unable to find anything particularly abnormal from an orthopaedic point of view on examining this man. I see that a diagnosis of conversion hysteria has been made and certainly it would appear to be just that on the basis of my examination today (…)

- In a report dated April 5, 1984, Dr. M. Charendoff (orthopaedics) noted that the worker "continues to complain of low back pain and left sciatica". Dr. Charendoff noted that the "examination of the lower extremities was within normal limits" and suggested that "this patient has a discogenic lesion of his lumbar spine associated with a significant psychogenic component".
- In a report dated October 13, 1989, Dr. B. Schacter (neurosurgeon) advised:

> On specific examination of the lower extremities, I did not demonstrate any indications that there was a sympathetic disturbance in the left leg. (…) This man has a long standing history, going back about eight years of problems related to his back and left lower extremity. He certainly appears disabled on examination, but I really do not feel that he exhibits an objective dysfunction of sufficient intensity to corroborate his subjective complaints. I do not see that there is any evidence of a sympathetic disturbance in the left lower extremity.

- As noted by the Appeals Officer, the file material was reviewed by a Board medical consultant who concluded:

> The different orthopaedic surgeons who saw the worker could not detect any organic basis for worker's ongoing left ankle pain and therefore it is not felt that the compensable left ankle injury of January 19, 1981 resulted in a permanent disability in the left ankle on an organic basis.

[47] In support of the appeal, the worker's representative refers to the comments provided by Dr. Kumra in his August 15, 2010, report to the effect that:

> Regarding the left ankle his diagnosis was grade 3 ankle strain with resultant residual hematoma and scaring, chronic pain syndrome, reflexive sympathetic dystrophy (RSD) and bone contusions.
>
> (…) Currently, the left ankle operates as if it is fused with poor mobility and calcification likely due to the RSD. He walks with an antalgic gait and feels less of a man. From my review of Dr. Artinian's reports and close to 20 years of observations the left ankle injury is a result of the WSIB injury in my opinion.

[48] The worker's representative also makes reference to the reporting from Dr. Wang including his January 26, 2011, report in which he advised:

> [The worker] injured his left ankle on a work injury in 1981, when it was fractured. Despite treatment, he has since then suffered constant pain at the site. On examination, the ankle is darkened in colour, and displays swelling and tenderness. Compared to the right ankle it is stiff, with limited range of motion.
>
> The injury continues to affect his functioning and activities of daily living (…).
>
> I understand that he was never compensated for the work injury to his ankle. In light of his continued suffering and disability, in my professional opinion, he should be assessed for compensation for his past ankle fracture.

[49] While I do not dispute the worker's testimony (as supported by Drs. Wang and Kumra) that he continues to experience pain radiating from his left ankle up his left leg, I prefer to place greater evidentiary weight on the opinions provided by the specialists who have examined this

worker and who have been consistent in their conclusions that the worker's left ankle fracture healed not long after the compensable accident and that there is no organic link between any symptoms the worker may currently be experiencing and the compensable accident. Noting that the worker has never been granted entitlement to benefits for Chronic Pain Disability (a condition mentioned by Dr. Kumra in his August 15, 2010, report) and that Chronic Pain Disability is not an issue under appeal, this portion of the worker's appeal must be denied.

(c) Entitlement for left plantar fasciitis/orthotics

[50] The case materials include a Tribunal Discussion Paper authored by Dr. T. Daniels, an orthopaedic surgeon entitled "Plantar Fasciitis (heel pain)". In the Discussion Paper Dr. Daniels indicates in part:

> Etiology: Heel pain may be caused by plantar fascia rupture, fat pad atrophy, stress fractures of the calcaneus, proximal plantar fasciitis, distal plantar fasciitis, plantar fibromatosis, tendonitis of the flexor hallucis longus, tumor of the calcaneus and nerve entrapment, or injury. The most common cause is inflammation of the proximal portion of the plantar fascia. There is no consensus regarding etiology. Snook and Christman wrote, "it is reasonably certain that a condition which has so many different theories of etiology and treatment does not have valid proof of any one cause". Factors associated with or aggravating this condition are better defined: age, sex, obesity, seronegative inflammatory disorders and activity levels. The average age is 45 years. Prevalence is twice in females vs. males. There may be a history of elevated stress to the foot as a result of increased activities, prolonged standing or weight gain. Physical activity certainly aggravates and can sometimes precipitate the heel pain. A retrospective review of injuries among runners cited plantar fasciitis as one of the five most common injuries. (…)
>
> Conclusion: (…) It is generally accepted that the primary etiology of heel pain is the result of repetitive tensile forces placed through aging tissue that is no longer capable of tolerating the stresses. While associated factors for this condition have been identified, no one activity is known to be the cause of heel pain.

[51] As Dr. Daniels' comments suggest, the medical community has had difficulty in identifying specific causes of the development of plantar fasciitis. As I understand it, Ms. Lok submits that the worker's left plantar fasciitis is related to the ongoing problems he has experienced with his left ankle. As noted earlier in this decision however, the worker's left ankle entitlement has been limited to the fracture he sustained in 1981 which, according to the information on file, healed relatively quickly thereafter. Given that I have not recognized that any of the worker's ongoing left ankle complaints can be causally related to the compensable accident, I, like the Appeals Officer, am unable to extend entitlement to cover the left plantar fasciitis and associated orthotics. This conclusion is similar to that reached by Dr. Malayil of the Board (in Memo No. 191), who, after reviewing the medical information on file, noted:

> (…)There was no mention of any plantar fasciitis up until December 1994, almost fourteen years following the compensable left ankle injury of January 18th, 1981. The foot specialist's report indicates that worker has bilateral pes planus deformity which is a risk factor for plantar fasciitis. In the absence of any structural damage to the left foot due to the compensable injury, I find it difficult to relate the plantar fasciitis to the compensable injury and as such the orthotics recommended by the foot specialist is not related to the compensable injury (…).

[52] As noted earlier in this decision, while I do not dispute that the worker may currently be experiencing pain and discomfort in the area of his left foot and ankle, I am not satisfied that there is sufficient evidence available to support a conclusion that the compensable accident was a significant contributing factor in the onset of this condition.

DISPOSITION

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

[54] The worker has suffered a worsening of his compensable low back condition. The Board will reassess his 10% PD award.

[55] The worker has suffered a worsening of his compensable psychiatric condition. The Board will reassess his 10% non-organic PD award.

[56] The worker does not have further entitlement with respect to his left ankle.

[57] The worker does not have entitlement for left plantar fasciitis/orthotics.

DATED: October 21, 2011

SIGNED: R. Nairn